Surreply Exhibit 1
Karasic *Misanin* Deposition Exhibit No. 3

EXHIBIT F

Transcript of the Testimony of

Dan H. Karasic, MD

Date: 7/13/2022

C.P. vs BLUE CROSS BLUE SHIELD OF ILLINOIS

NELSON COURT REPORTERS
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IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WASHINGTON

AT TACOMA

C. P., by and through his parents, Patricia Pritchard, and Nolle Pritchard; and PATRICIA PRITCHARD,	)	
Plaintiffs,	)	
vs.	)	No. 3:20-cv-06145-RJB
BLUE CROSS BLUE SHIELD OF ILLINOIS,	)	
Defendant.	)	

REMOTE
VIDEOTAPED DEPOSITION UPON ORAL EXAMINATION OF
DAN H. KARASIC, MD
Wednesday, July 13, 2022 at 9:00 a.m.

Via Zoom Remote Videoconference
Witness location: San Francisco, California

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TESTIMONY

EXHIBITS

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EXHIBITS (cont'd)

BE IT REMEMBERED that on Wednesday, July 13, 2022, in San Francisco, California, at 9:00 a.m., via Zoom remote videoconference, the deposition of DAN H. KARASIC, MD was taken before Sierra Zanghi, Certified Court Reporter. The following proceedings took place:

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THE VIDEOGRAPHER: Today is July 13th, 2022. The time is 9:01 a.m. This is Volume I in the deposition of Dr. Dan Karasic in the U.S. District Court for the Western District in Tacoma in the matter of C. P., et al, v. Blue Cross Blue Shield of Illinois, Cause No. 3:20-cv-06145-RJB.

This is a remote Zoom deposition noticed by Defense Attorney Stephanie Bedard. My name is Kurt Schultz. I'm contracted by Royal Video Productions, whose principal place of business is 950 Northwest Firwood Boulevard, Issaquah, Washington 98027. The phone number is 425-391-6809.

At this time, I would ask counsel to identify themselves.

ATTY. BEDARD: Good morning. My name is Stephanie Bedard. I'm counsel for Blue Cross Blue Shield of Illinois.

ATTY. GONZALEZ-PAGAN: Good morning. Omar

Gonzalez-Pagan, counsel for the plaintiffs with Lambda Legal.

THE VIDEOGRAPHER: Thank you. Today's court reporter is Sierra Zanghi of Nelson Court Reporters. You may swear the witness in.

DAN H. KARASIC, being first duly sworn to tell the truth, the whole truth, and nothing but the truth testified as follows:

EXAMINATION

BY ATTY. BEDARD:

Q. Good morning, Dr. Karasic. As you may have heard a minute ago, my name is Stephanie Bedard, and I represented Blue Cross Blue Shield of Illinois. Before I say anything further, am I pronouncing your name correctly, "Karasic"?

A. Yes.

Q. Okay, good. I just wanted to make sure. So as you know, the plaintiff -- one of the plaintiffs in this case is Casey Pritchard, but because Casey is a minor, I'm going to be referring to him throughout this deposition as "C. P." I just wanted to make sure you understood who I was referring to when I said that.

A. Yes.

Q. Okay. Great. And you understand you're under oath today?

A. Yes.

Q. Well, I understand you've had your deposition taken before, but I don't know if that was in our Zoom remote deposition era or not, so I'm going to go over a few ground rules that will be particularly important in this Zoom era.

And the first is to do our absolute best to try not to talk over each other. It's easy to do in person, and it's even easier to do via Zoom. So I will do my best not to speak over you, and I would ask that you do the same; does that work?

A. Yes.

Q. Okay, great. And also, because this is a remote deposition, we'll need you to affirmatively answer every question. Simply shaking your head yes or no, while on the video, won't be picked up by the court reporter. Does that make sense?

A. Yes.

Q. And if you need a break at any time through the course of your deposition, feel free to raise your hand, flag me down. I may finish a line of questioning or finish asking you about a specific exhibit, but then we can certainly take a break.

A. Yes.

Q. Okay. Great. And I also, you know, I tend to try to give everyone a break every hour or so. But again, if you need something more frequent or between those times, that's perfectly fine.

So if I ask you a question and you are confused by it, please feel to ask me to rephrase. Does that make sense?

A. Yes.

Q. Okay. Great. And by that same token, if you answer my question, I will assume you have understood the question asked. Does that make sense?

A. Yes.

Q. Great. Dr. Karasic, what is your current address? Where do you currently reside?

A. 86 Montezuma Street, San Francisco, California 94110.

Q. And is that where you're located today?

A. Yes.

ATTY. BEDARD: Dr. Karasic, I am going to share my screen and share with you what has been marked as Defendant's Exhibit 1.

(Exhibit 1 marked for identification.)

Q. (BY ATTY. BEDARD) Can you see that exhibit?

A. Yes.

Q. Great. Have you seen this deposition subpoena before today?

A. Yes.

Q. And how did you prepare for today?

A. I reviewed my statement, reviewed a few of the papers listed in my report, and I had two meetings with counsel.

Q. When were those meetings?

A. One was on -- it would have been July 10th, and the other one was July 8th.

Q. And when you refer to your counsel, are you referring to Mr. Gonzalez-Pagan who's sitting here today?

A. Yes.

Q. Okay. Was anyone present during the course of your meetings, other than the two of you?

A. There were other members of the legal team.

Q. Okay. Do you remember their names?

A. No.

Q. Was Ele Hamburger a part of that meeting as well?

A. Yes.

Q. Okay. Was there anyone in the meeting who was not legal counsel?

A. No, I don't believe so.
Q. And did you collect documents to provide to plaintiff's counsel in advance of your deposition today?
A. Yes. Well, I provided them with references to my statement and the bibliography.
Q. And are there any -- first, Dr. Karasic, when you're referring to your "statement" -- I just want to make sure we're on the same page -- this is your expert disclosure that was disclosed to defense counsel on June 27th, right?
A. Yes.
Q. Okay, great. Just want to make sure we're talking about the same document here. So when you were preparing and drafting your statement or your disclosure, are there any documents that you reviewed that you did not provide to plaintiff's counsel?
A. I'm sure -- I mean, I, you know, read widely in the field of transgender health, and so there may be other documents that shaped my opinion. But the kind of primary documents that I'm basing my opinion on are in my report.
Q. Okay. And are there -- would you say that the documents that you collected to provide to

plaintiff's counsel, would those represent the primary documents you relied on in your report?
A. Yes.
Q. Okay. And what documents do you have in front of you today?
A. The only document I have in front of me is I have a paper copy of my expert report for convenience, if we refer to it.
ATTY. GONZALEZ-PAGAN: And just to clarify for the record, Stephanie, and completeness, Dr. Karasic provided some documents. We also collected some of them ourselves from his bibliography that he provided to us. So I just wanted to make sure there's clarity on the record.
ATTY. BEDARD: Okay. And just to clarify, the production that was provided to defense counsel that begins with Bates No. "KARASIC" includes those --
ATTY. GONZALEZ-PAGAN: Right. Well, it includes the full body, yes.
Q. (BY ATTY. BEDARD) Okay, great. And then Dr. Karasic, just to circle back, the only paper document you have in front of you today is your expert report, right?
A. Yes.
Q. Okay. And Dr. Karasic, I understand from that

report that you have previously been deposed. How many times have you been deposed before today?
A. So as I list in that document, in recent years, I've been deposed three times. I was also deposed in 2014. And a couple of times relating -- I was deposed relating to patient care. And each time, it was a patient of mine in my practice many years ago who was involved in a lawsuit where I was deposed related to that lawsuit.
Q. Okay. So just to break down what I understand you're saying, Dr. Karasic, let's start first with the three times that you've recently been deposed. For each of those three times, were you deposed as a treating physician on behalf of someone you'd seen in your practice?
A. No. The three times --
Q. So --
A. The three times --
Q. I apologize, go ahead.
A. The three times that are listed in my expert report are the three times I was deposed as an expert.
Q. Okay. And what were the names of those three cases, if you can recall?
(Atty. Hamburger joined the proceedings.)
A. Sure. So one is Kadel v. Folwell, and one is Fain

v. Crouch, and one is Brandt v. Rutledge.
Q. And in your capacity as an expert in each of those three cases, were you providing expert testimony on gender-related issues, gender-related care?
A. Yes.
Q. Okay. So then in addition to those three cases in which you were deposed that are included in your expert report, you also mentioned just now that you have previously been deposed as a treating physician. Can you walk us through each of those times?
A. Sure. So they were many years ago. I don't remember all the details. One was a patient that -- of mine at San Francisco General who was suing the San Francisco Police Department for being injured by a police officer.
And another as a treating physician was a patient of mine who was engaged in litigation, and I think I was essentially asked about the emotional effect of the litigation on that person.
So those are the two that I can recall. And yeah, so that's the treating physician.
Q. Did either of those two cases involve gender-related issues?
A. No.

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Q. And those two cases are the only cases you recall providing deposition testimony in a treating capacity, right?
A. Yes.
Q. Okay. And are these three cases where you discussed providing deposition testimony in an expert capacity, are those the only three cases where you have provided deposition testimony in an expert capacity?
A. No. I mentioned there was one in 2014 where I was deposed as an expert.
Q. Okay. Can you tell us more about that case, including the case name, if you remember?
A. Sure. It was Cabading v. Cal Baptist University.
Q. And what do you recall about that case?
A. Sure. So there was a transgender woman who had been admitted to Cal Baptist, to their nursing school, and shortly prior to starting school, they found out that she was transgender, and they revoked her admission.
Q. And you provided expert opinion in that case on behalf of the plaintiff you referenced?
A. Yes. Yeah.
Q. Okay. In addition to the 2014 case you just mentioned and the three cases we've already

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discussed, are there any other cases where you provided testimony in an expert capacity?
A. It wasn't as a -- in a deposition format, but I did testify in the Province of Ontario, XY v. Ontario. I testified in 2010. I believe the case was -- the decision was in 2012. And it was before the Province of Ontario Tribunal of Human Rights -- a human rights court that some Canadian provinces have.
THE VIDEOGRAPHER: Stephanie, you're still sharing that Exhibit.
ATTY. BEDARD: That's fine. Thank you.
THE VIDEOGRAPHER: Okay.
ATTY. BEDARD: I appreciate the reminder. I do tend to leave them up sometimes.
Q. (BY ATTY. BEDARD) So Dr. Karasic, in the XY case you just mentioned, you were testifying in an expert capacity, right?
A. Yes.
Q. And that was in court?
A. It was in a human rights court, which they have in Ontario. I don't believe there is an equivalent in the US.
Q. But you were testifying in an expert capacity in front of that tribunal?

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ATTY. GONZALEZ-PAGAN: Objection to form.
A. Yes.
Q. (BY ATTY. BEDARD) Were there any other instances in which you testified in a Canadian court or tribunal?
A. I did an expert statement in a case, CF v. Alberta, but I did not -- I was not deposed, and I didn't testify. I just provided an expert statement which was accepted.
Q. Okay. So just to backtrack a little bit. Setting aside the appearance in front of the Canadian Human Rights Tribunal, we've previously discussed the instances in which you provided deposition testimony, either as an expert or as a treating physician. Can you please walk me now through any instances in which you provided trial or other live or in-court testimony? Again, either as a treating or as an expert -- treating physician or expert witness.
A. So I have not -- in the US, I have not provided live in-court testimony.
Q. Is there any other testimony you've provided in any capacity that we have not yet talked about?
A. Meaning deposition or live court testimony?
Q. Good question. Let me clarify. Let me extend it as well to expert reports. Are there any expert

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reports you've provided in any case other than those in which we've already spoken about today?
A. Yes. I did an expert report in a case in Ohio. I don't recall the name of the case right now, but I did an expert report on that case. And that would have been in 2020, I think. I think it may be on my -- the case name may be on my CV. Yeah, Drew Glass v. City of Forest Park, 2021. And so, yeah, it's mentioned on my -- in my report.
Q. And in that case, Dr. Karasic, you provided an expert report, but you were not deposed, and you did not or have not testified in court?
A. Yes.
Q. Okay. Great. And have you ever personally been involved in litigation before, as a plaintiff?
A. No.
Q. What about as a defendant?
A. No.
Q. Dr. Karasic, I am now going to show you what has been marked as Defendant's Exhibit 2.
(Exhibit 2 marked for identification.)
Q. (BY ATTY. BEDARD) Defendant's Exhibit 2 is the expert disclosure that you have made in this case, which you've been referring to as a statement, which is fine. Can you see that okay?

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A. Yes, I was just pulling it up on my big screen.
Yes.
Q. Are you able to see the one that I'm actually sharing? The reason I ask is I may scroll through it.
A. Oh, okay. Yes.
Q. Okay. Great. It'll probably just be easiest if we're all looking at the same one, same page, same paragraph, that type of thing. Did you draft this report?
ATTY. GONZALEZ-PAGAN: And just for clarity of what's been shown on the screen, it only shows the caption. It doesn't show the document title. Thanks.
THE WITNESS: Yes.
ATTY. BEDARD: So Omar, can you see the exhibit now?
ATTY. GONZALEZ-PAGAN: Yes, yes. Now it shows, thank you.
ATTY. BEDARD: Okay, great.
Q. (BY ATTY. BEDARD) So Dr. Karasic, I'm going to repeat my question again: Did you draft and prepare this report?
A. Yes.
Q. Did anyone assist you in preparing it?

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A. Yes.
Q. Who was that?
A. So Omar Gonzalez-Pagan assisted me. We had -- I'd been an expert in a case that Omar had been involved in, Kadel. And I had done another case, Fain, with Lambda Legal. And so there are aspects of the report that have kind of carried through from prior reports, and Omar assisted in -- in that aspect of kind of carrying over what I had provided as an expert in these prior cases, working with Lambda Legal.
Q. And other than Omar and other individuals at Lambda Legal, is there anyone else who assisted you in preparing the report?
A. No.
Q. Did anyone other than Omar or someone at Lambda Legal review the report before it was finalized?
A. No.
Q. And what documents did you review in preparing this report?
A. So I reviewed quite a number of documents. I don't think I could list them in any complete way, but I'm always reading, you know, in transgender health. And so any review for this, you know, just overlaps with, you know, my reading in transgender health.

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But certainly I reviewed a number of the papers I cited in the report.
Q. So in addition to medical literature on gender-related issues, what documents did you review that were specific to the plaintiff, C. P.?
ATTY. GONZALEZ-PAGAN: Objection to form.
A. So I reviewed medical records that were provided to me -- C. P.'s medical records.
Q. (BY ATTY. BEDARD) Did those include medical records from CHI Franciscan Health and Dr. Garza?
A. They were from, as I recall, from Polyclinic, from Dr. Hatfield; there was Dr. Garza, I believe; and there was a -- I believe her name was Sharon Booker. There was a mental health social worker's letter that I reviewed.
Q. It's my understanding, by the way, that Ms. Booker works at the Center for Child and Family Therapy. So I may refer to those records either as her records or that facility's records.
A. Sure.
Q. Are there any other C. P.-specific records that you reviewed?
A. Not that I can recall.
Q. Did you review a psychological evaluation of C. P. from 2021?

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A. Oh, yes. I did. The one -- I think it was in regards to ADHD.
Q. Okay. And did you review any records from Blue Cross Blue Shield of Illinois in preparing your report?
A. The only material I reviewed from Blue Cross Blue Shield of Illinois that I can recall was their statement of provision of transgender care for their policies that are not for self-insurance.
Q. And Dr. Karasic, there were some new documents we received from the Polyclinic recently, and recently provided those to plaintiff's counsel. I don't know whether you have seen these yet today. I'm going to show them to you so that you can see them now.
A. Okay.
Q. Let me know if you've seen them previously.
A. I don't know if I've seen them previously.
Q. Okay.
ATTY. GONZALEZ-PAGAN: Stephanie, you're not -- you stopped sharing. Thank you.
(Exhibit 3 marked for identification.)
Q. (BY ATTY. BEDARD) So Dr. Karasic, can you see the document I'm showing you now that says "T-Scan Corporation" at the top?
A. Yes.

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Q. I'm introducing what's been marked as Defendant's Exhibit 3. These are those new records from the Polyclinic we received this week and which have been provided to plaintiff's counsel. We'll go through these later today, but I just wanted to give you a frame of reference of what I was talking about when I refer to the "new Polyclinic records," as compared to what you've previously reviewed.

A. Okay.

Q. And in particular, I wanted to draw your attention to the PDF Page 30. Do you see here where it says "CONSENT FOR SURGERY" up at the top?

A. Yeah. Let me pull it up on a larger screen, because the Zoom screen is a small one, so it's a little hard for me to see.

Q. Dr. Karasic, I'm happy to zoom in on my screen if need be. It will be easier if we can ensure we're looking at the same document the whole time, rather than you looking at your own version.

A. Okay.

Q. But if you can't see it, just let me know, we can come up with another solution. Is that better there? Can you see that?

A. Okay. Yeah.

Q. Okay, great. So do you see where it says "CONSENT

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FOR SURGERY"?

A. Yes.

Q. And that this is a record for C. P.?

A. Yes.

Q. I'm scrolling down. It says that this consent authorizes Dr. Jeffrey Kyllo to perform a bilateral mastectomy?

A. Yes.

Q. Okay, great. And we'll come back to this, but do you see at the bottom where it says "Patient Signature," and it has C. P.'s signature as the patient signature?

A. Yes.

Q. With a witness signature as well, right?

A. Of the parent, yes.

Q. Yes. Okay. All right.

So Dr. Karasic, we've reviewed a bit of your educational background and qualifications from what's in your report, but if you would for a moment tell me a bit about your educational background first. Can you let me know any schools you attended and any degrees you received?

A. Sure. I received my bachelor's degree from Occidental College in Los Angeles, and then went to Yale University School of Medicine in New Haven.

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And then I trained in psychiatry at the UCLA Neuropsychiatric Institute. The last year of my residency overlapped with an NIMH fellowship. And then in 1991, I started working as faculty at University of California, San Francisco.

Q. Okay. And are you currently still employed as faculty at UCSF?

A. So I am an emeritus professor of psychiatry. I retired from being full-time employed by UCSF in 2020. Since then, I've done a small amount of work for UCSF as recall faculty, which is something I expect to continue, but just a very small amount of, you know, paid work for UCSF, since 2020.

Q. And since you obtained your psychiatry degree, have you also been in private practice since that time?

A. Yes. So while I was at UCSF, as part of my work, I did a faculty practice in addition to the clinics I worked in. And then in 2020, when I retired, I started a private practice. And that's my primary employment now.

Q. What is the name of that private practice?

A. Just "Dan Karasic, MD."

Q. Are there any other physicians within that private practice with you?

A. No.

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Q. And you previously mentioned that you had testified as a treating physician in the past. So at those times, where was your private practice located?

ATTY. GONZALEZ-PAGAN: Objection. Form.

A. So at that time I was not in private practice. I did something like a private practice that was called a faculty practice, because the money would go to UCSF. But most of my work while I worked at UCSF was in various clinics. So it was at a UCSF clinic in each of those two cases where a patient in that clinic was involved in litigation, and I was deposed as a treating physician.

Q. (BY ATTY. BEDARD) So essentially, when we talk about something along the lines of private practice, you were in a faculty practice from the time that you achieved your degree in psychiatry until 2020, and it was in 2020 when you began your own private practice outside of your faculty practice, right?

A. Yeah. I mean, the faculty practice refers to something that is structured somewhat like a private practice. But I also -- much of my work was in -- as a psychiatrist in various clinics, various UCSF and San Francisco Department of Public Health clinics where it wasn't really like a private practice. It was going into a medical or mental

health clinic and consulting or taking care of patients.

Q. And were any of those clinics specifically focused on the provision of transgender-related or gender-related care?

A. Yes. So I was the psychiatrist for the Dimensions Clinic for trans youth from 2003 until 2020, when I retired. And I was also the co-lead and co-founder of the gender team at UCSF Gender Alliance Health Project, and that gender team started around 2011. But even before that, we were not with a formal team, we were taking care of transgender people. USCF Alliance Health Project is a mental health clinic of UCSF that provides mental health care for LGBTQ patients.

Q. And you also previously mentioned a fellowship. Was there a specific specialty for that fellowship?

A. Yes. It was in mental health services for people with HIV/AIDS.

Q. And are you a member of any professional organizations?

A. Yes. I am a distinguished life fellow of the American Psychiatric Association, and I am a member of the World Professional Association for Transgender Health.

Q. Is that commonly referred to as WPATH?

A. Yes.

Q. So walk me through, if you can, your involvement with WPATH. Are you a member? Are you on the board? What's been the extent of your involvement over the years?

ATTY. GONZALEZ-PAGAN: Objection. Form.

A. Sure. So I first joined as a member in 2001. I became involved in the late 2000s with committees relating to DSM and ICD diagnoses WPATH committees. And then I became involved as a co-author of WPATH's Standards of Care, Version 7, which was written, I would say, between 2009 and 2011.

And then from 2014 to 2018, I was on the board of directors of WPATH.

THE COURT REPORTER: And Counsel Gonzalez-Pagan, did you have an objection?

ATTY. GONZALEZ-PAGAN: Yes. I said objection to form prior to his answer.

THE COURT REPORTER: Thank you.

Q. (BY ATTY. BEDARD) And Dr. Karasic, what does -- what was the extent of your involvement on the board of directors of WPATH?

A. We had a very active board, and so we had addressed quite a number of issues relating to -- especially

to organizing conferences, to providing trainings to healthcare providers inside and outside of the US. We provided consultation to international organizations and government and governments outside of the US, as well as the US. And so it was an active time in that regard. I also -- we were restructuring the organization to have regional chapters, and I was the conference chair for the first USPATH conference in 2017, which was organized, actually, by WPATH because the USPATH board wasn't elected until 2018.

Q. (BY ATTY. BEDARD) And I understand you were on the board of WPATH from 2014 to 2018. So from 2018 to the present, would you consider your involvement in WPATH to be as a member or in a different capacity?

ATTY. GONZALEZ-PAGAN: Object to form.

A. So I'm a member. I've also been the chapter lead for the mental health chapter, which involves mental health care for adults in Standards of Care 8.

Q. (BY ATTY. BEDARD) What does it mean to be a chapter lead?

A. So I guess I would say in addition to that, I'm on the larger committee for Standards of Care 8. But within the chapter, it involved, with the editors of SOC 8, selecting other authors for the chapter, and

then writing possible statements for Delphi approval, which was a way of achieving kind of a supermajority approval of each statement, and then writing explanatory text. And so the chapter lead is the equivalent of a first author on a paper. The chapter was ultimately my responsibility, but I worked with the other authors on the chapter.

Q. And did you say that after you finished drafting a chapter, it went for Delphi approval? Did I hear you correctly?

A. Yes. Delphi approval was not for the whole chapter, but the previous standards of care were the -- standards of care had approval by consensus. Standards of Care 8 grew too large for that, so there would be -- there's a process which is called Delphi process for coming to agreement on kind of central statements of a document.

And so our chapter, with the editors, ended up coming down to ten statements that we submitted for Delphi approval from the 120 to 140 people involved with Standards of Care 8 -- the other authors of Standards of Care 8. And a statement could receive 75-percent approval to be an approved statement.

If it received less than that, for each statement, each reviewer, which was the 120 to 140

people, could put down comments. And particularly, if a statement received less than 75 percent, there was an opportunity to modify the statement and bring it back to Delphi.

Q. Okay. So to make sure I understand how this process works, there would be one or more primary drafters of a specific statement in the next Standards of Care version, and then it would go then out for Delphi approval. And Delphi approval means weigh-in on that statement by the 120 to 140 members who are weighing in on that statement, right?

ATTY. GONZALEZ-PAGAN: Object to form.

A. Yes -- yes, who are part of the Standards of Care 8 Committee, really, the authors of Standards of Care 8. So Standards of Care 8 is a much larger document than the previous Standards of Care. And so there were about 20 chapters. And so each chapter had probably five to seven members, at least.

And so all of those people who were involved in any of the chapters could -- were given a link to weigh in and comment on each statement that may have been drafted by a group.

So the statement would originally be drafted by perhaps five to 17 people, led by a chapter lead, in consultation with the three editors, and then that

statement would be sent out to all of the authors. And it was considered agreed upon if 75 percent of people agreed upon it. If it was not agreed upon, then the authors -- the original authors of the statement had all of the comments, what people disagreed with about the statement, and could -- had an opportunity to later go back to the Delphi process with a modified statement to see if that would be approved.

Q. (BY ATTY. BEDARD) So what is the current status of the Standards of Care 8?

A. My understanding is that it's done, and that it is going to be released imminently. We have -- I was asked to give a talk about the mental health chapter at the WPATH conference in Montreal, which is in September of this year. And so I don't know whether they plan to do a public release during the conference, but I would imagine -- or if the release will be before that -- but I would imagine that the document would be released by September.

Q. And just taking a quick step back, we've discussed membership in WPATH. Who is eligible to be a member of WPATH?

A. So yes. We discussed membership in WPATH, which is different from membership on the Standards of Care 8

Committee. So when I was referring to those members of Standards of Care 8 Committee, people had to apply with a CV and a statement. And so it was a competitive process to be on one of the chapters of Standards of Care 8.

To be a member of WPATH, one has to apply to WPATH. To be a full member, one is supposed to be a health professional or health-related academic. There are a few lawyers who work with the interface of the law and transgender health, I think, who are full members. But otherwise, people are health professionals, some who are also health academics, some are -- many of the members are clinicians.

Q. Is there any sort of degree requirement to be a member of WPATH?

A. So there's not a -- to be a full member of WPATH, there's not a degree requirement, but to be a health professional that would, you know, or an academic, you would need a degree, certainly.

So there are student members. So there are people who are working on degrees as student members. They're not full members of WPATH. And there is some associate membership -- I believe it's a nonvoting membership that people can get who are not health professionals.

Q. And Dr. Karasic, in addition to WPATH, are you also familiar with the Endocrine Society?

A. Yes.

Q. And what is that?

A. So it's -- the Endocrine Society is a professional organization of endocrinology.

Q. Is it specifically focused on gender-related issues?

A. No. The Endocrine Society deals with endocrinology and other aspects, aside from gender care.

Q. So to make sure I understand this correctly, then, the Endocrine Society looks at gender-related issues but also has a scope that is broader than just gender-related issues?

A. Yes. Gender-related issues are just one of many issues that the Endocrine Society addresses.

Q. And to be a member of the Endocrine Society, do you need to have a degree in endocrinology?

A. So I'm not a member of the Endocrine Society, and I can't say I know what their criteria are. But my understanding is it's an organization of endocrinologists, so largely people who have trained first in internal medicine, and then in endocrinology, or first to pediatrics and then in pediatric endocrinology.

Q. But is there some overlap between the two groups in

terms of the subject matter that they cover?
A. Yes. In terms of the Endocrine Society and WPATH?
Q. Correct.
A. Yeah. So most people in WPATH are also part of another organization. So for example, I've been active in the American Psychiatric Association as a psychiatrist. Somebody who's a family medicine doctor might be in the American Academy of Family Medicine; or a pediatrician, the American Academy of Pediatrics. And so endocrinologists who work in gender health may well be a member of the Endocrine Society, which -- related to endocrinology more generally -- as well as being endocrinologists within WPATH.
Q. And you actually read my mind with what was going to be my next question, which is -- since you're a member of WPATH, you're a member of American Psychology Association, I believe you said -- are there any other professional organizations that you are a member of?
ATTY. GONZALEZ-PAGAN: Objection.
A. So I'm a member --
THE COURT REPORTER: Counsel -- one moment. Counsel Gonzalez-Pagan, did you have an objection? I wasn't able to hear it.

ATTY. GONZALEZ-PAGAN: Objection to form.
THE COURT REPORTER: Thank you.
A. So I'm not a member of the American Psychological Association, I'm a member of the American Psychiatric Association. And currently, I am only a member of the American Psychiatric Association and WPATH.
Q. (BY ATTY. BEDARD) And Dr. Karasic, let's talk for a minute about what your current private practice looks like. So -- and I understand that your private practice was first started in about 2020. How many patients do you currently see per year?
A. I don't have -- I don't have those numbers off the top of my head. Yeah. I don't think I can tell you. I don't keep those statistics, although I suppose I could, you know, review how many charts I have, but I haven't.
Q. Would you say that it's over 100 patients?
A. Yes.
Q. And somewhere less than 250 patients?
A. I just hesitate to speculate under oath, in that I don't know what the numbers are.
Q. Understood. That's fine. We're not going to hold you to a specific number today.
To the best of your knowledge, how many of your

current patients identify as transgender?
A. So that was something I did look at, just a typical week, and -- a little while back. And about two-thirds of my patients are transgender.
Q. And how many of those transgender patients are minors?
A. And so about half of my transgender patients are minors, or I started seeing as minors in 2020. Some may have turned 18 since then. But when I -- the reason I give those numbers is at one point I just looked at my schedule, and just for a given week, and saw it was about one-third transgender minors, about one-third transgender adults, and about one-third cisgender patients, mostly adults.
Q. And throughout the course of your career and your practice, have you ever worked with any physicians from the Polyclinic?
A. No.
Q. Prior to reviewing C. P.'s medical records, were you familiar with Dr. Kevin Hatfield?
A. No.
Q. And what about Dr. Jeffrey Kyllo?
A. No.
Q. The same question for Ms. Sharon Booker with the Center for Child and Family Therapy. Are you

familiar with that practice group?
A. No.
Q. And are you familiar with Ms. Booker?
A. No.
Q. And have you reviewed the reports of plaintiff's two other experts in this case, Dr. Ettner and Dr. Schechter?
A. I actually don't believe I have.
Q. Are you aware that Dr. Ettner and Dr. Schechter have provided expert disclosures in this case?
A. Yes.
Q. And have you ever worked with either of them previously?
A. Yes. I was on the WPATH board with both Dr. Schechter and Dr. Ettner. So I've not worked clinically with them. I've worked with both of them on the board, and we have worked together on educational projects -- on projects to train healthcare providers in transgender health.
Q. What about Dr. Frank Fox, who we understand has or will also be disclosed as an expert? It's Frank G. Fox.
A. No.
Q. And as we talk about your practice and the number of transgender -- the patients you see who identify as

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transgender, I'm assuming transgender-related issues, gender-related issues are something that you would consider to be a specialty, right?
A. Yes.
Q. Did you receive any specialized training in gender-related issues?
ATTY. GONZALEZ-PAGAN: Sorry, just before you finish the question, Dr. Karasic, if you can hold off just a couple of seconds for me to lodge an objection, I know that it's just -- I believe the court reporter may appreciate it. I would appreciate it. So if you just kind of hold off a couple of seconds before answering.
THE WITNESS: Yes, I will -- I will try. Sorry.
ATTY. GONZALEZ-PAGAN: Apologies, Stephanie. Please. I didn't mean to interrupt.
ATTY. BEDARD: That's all right. I'll repeat my question. We can have the weighted pause.
Q. (BY ATTY. BEDARD) Dr. Karasic, did you receive any specialized training in gender-related issues?
A. Yes. I did my psychiatry residency at UCLA, UCLA Neuropsychiatric Institute, and I received my first training in transgender care there with Robert Stoller, who coined the term "gender identity." He

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had been working with transgender people at UCLA since the 1950s.
And I also worked with -- received training from Richard Green, who was a psychiatrist at UCLA at that time. He did the Feminine Boy Study at UCLA. And so I received training about gender-nonconforming boys from his work.
Q. Anything else?
A. Well, yes. So much of what I did as a faculty member were trainings that I organized, of which there were many. I probably organized more trainings on transgender health -- and more educational sessions on transgender health over this last 30 years at American Psychiatric Association meetings, probably than anyone else.
But even if I were the chair of a session, I was one of a panel of presenters. And so I received training, certainly, by -- from my peer psychiatrists.
I was also faculty on an American Psychiatric Association CME training with fellow psychiatrists. So there were many opportunities over the years to be educated by my peers as well.
Q. And Dr. Karasic, is everything in the qualifications section of your expert report accurate to the best

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of your knowledge?
A. I believe so.
Q. And is everything listed in your CV attached to your expert disclosure accurate, to the best of your knowledge?
A. I believe so.
Q. Are there any recent updates to your background or qualifications that do not currently appear on your CV?
A. Well, I recently went from being a distinguished fellow of the American Psychiatric Association to a distinguished life fellow of the American Psychiatric Association, which was just an achievement I guess I got by surviving. And I don't -- since updating my CV -- since I'd worked for one employer my entire career, it was always a challenge updating my CV. And since I retired in 2020, it's not something I do very often. I've added some legal cases with expert witness work that I've done since retirement. But there's no doubt that there are things that I've done that are not listed on my CV.
Q. Well, hopefully the recent change in your designation for the APA means you no longer have to pay dues.

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A. I used to, but they changed that. So now they have, like, a semi-retired status. But it was, until a couple years ago, that when you reached that status, that you no longer had to pay dues. But the APA decided -- I think psychiatrists are getting so old that they decided that that was not a viable proposition indefinitely.
Q. Understood.
ATTY. BEDARD: Omar, I am about to go into a series of questions about a specific exhibit. It may be a good time to take a quick five-minute break. We're right at a hour mark, if that works for everyone?
ATTY. GONZALEZ-PAGAN: Yeah. Five minutes is fine.
THE VIDEOGRAPHER: Okay. We are going off the record at 10:03.
(Break from 10:04 a.m. to 10:10 a.m.)
THE VIDEOGRAPHER: We are back on the record at 10:10.
ATTY. BEDARD: Dr. Karasic, I'm going to go back now to Exhibit 2, which is your expert disclosure, and I'm going to share my screen with you.
THE WITNESS: Okay.

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Q. (BY ATTY. BEDARD) Can you see my screen?
A. Yes.
Q. So I'm going to go now in your expert report to Paragraph 17. And in Paragraph 17, I understand from your disclosure that you conducted an interview with C. P. on March 18th of 2022; is that correct?
A. Yes.
Q. And it was via Zoom?
A. Yes.
Q. And were C. P.'s parents present for part or all of that interview?
A. Yes. C. P.'s parents were present at the beginning and at the end, and in the middle portion of the two hours, I was just with C. P.
Q. And had you reviewed C. P.'s medical records prior to that March meeting with C. P.?
A. Yes.
Q. What about the records from Sharon Booker and the Center for Child and Family Therapy?
A. Yes.
Q. And based on your review of those records and your meeting with C. P., is it your understanding that C. P. first met with Dr. Hatfield in 2016?
A. Yes.
Q. And C. P. was ten years old at that time, right?

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A. C. P. in 2016 may have been 11. I think 2016 -- C. P.'s year of birth is 2005 -- early 2005. So 10 or 11.
Q. And C. P. first received a puberty blocker that same year, right?
A. Yes.
Q. And that was age 10 or 11?
A. Yes. I believe that was age 11 that C. P. received the puberty blocker.
Q. And then is it your understanding that C. P. then started testosterone cream in 2017 at the age of 11 or 12?
A. I think the testosterone cream was started just when C. P. turned 13, is my recollection, so around early 2018.
Q. Is it your understanding that there was a period of time in which C. P. was prescribed testosterone cream, and then at one point switched to testosterone injections?
A. Yes.
Q. Do you recall, from your review of the records and meeting with C. P., when that was? In other words, how old C. P. was when he began the testosterone injections?
A. Let's see. The testosterone cream was right

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around -- I think shortly after C. P. turned 13. The -- I have reviewed the -- saw the record of when the testosterone injections started, but I can't remember whether C. P. was 13 or 14 at the time of the first injection.
Q. And then C. P. also received a bilateral mastectomy, right?
A. Yes.
Q. And that was in 2019?
A. And that was in 20- -- let's see. I think that the -- yeah, I think it was maybe December of 2019. Yeah, I think so.
Q. Let's take a look further down in your expert report.
ATTY. GONZALEZ-PAGAN: Stephanie, just for the sake of completeness, I believe, like, your Adobe panel on the -- what would be right-hand side is blocking a bit of the text. Do you see the arrow in the middle? It can be collapsed.
ATTY. BEDARD: Thank you. Is that better?
ATTY. GONZALEZ-PAGAN: Yes.
Q. (BY ATTY. BEDARD) Dr. Karasic, can you see the full text of the document I'm showing you right now?
A. No. Should I hide thumbnail video?
Q. Is the Zoom screen blocking it?

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A. Yes, partially.
Q. You can move the Zoom screen portion around.
A. Okay. All right. Okay. Let's see. I moved it down, and it brought it down to the lower part of the screen, so I'll just ask you to scroll up if you need -- if I need --
Q. Sure. I'd be happy to do so. So Dr. Karasic, I'm looking at Paragraph 70 and 71 of your expert report. Does this help refresh your recollection as to the dates of the various procedures and C. P.'s age for each of those procedures?
A. Yes.
Q. And do you see in Paragraph 71, and I'm going to read from your report now, where it says, "[C. P.] states that Dr. Hatfield discussed the risks and benefits of each intervention extensively with [C. P.] and his parents." Do you see that?
A. Yes.
Q. And would you agree with that statement?
A. That is what I was told by Casey and his parents.
Q. And I guess my question though, Dr. Karasic, is understanding that that's what Casey told you -- what C. P. told you, would you agree with the statement that Dr. Hatfield discussed the risks and benefits of each intervention extensively with C. P.

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and his parents?
ATTY. GONZALEZ-PAGAN: Objection to form.
A. Well, the sentence says, "Casey states that Dr. Hatfield discussed risks and benefits of each intervention." So when I was doing my expert statement, it was what Casey had told me.
But my recollection is, in reviewing the medical records of Dr. Hatfield, that Dr. Hatfield also documented having discussed risks and benefits of interventions with C. P. and C. P.'s parents.
Q. (BY ATTY. BEDARD) And would you agree that that was an extensive discussion of the risks and benefits?
ATTY. GONZALEZ-PAGAN: Objection. Form.
A. So the word "extensively" was from my discussion with Casey and Casey's parents.
Q. (BY ATTY. BEDARD) Understood. But I'm asking you a slightly separate question, perhaps inartfully. I'm asking whether you agree that Dr. Hatfield's discussion of the risks and benefits with C. P. and his parents was extensive?
ATTY. GONZALEZ-PAGAN: Objection. Form.
A. My recollection is that there is documentation of risks and benefits, including bone health and fertility, that Dr. Hatfield charted. But the characterization comes from the interview. I did

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not interview Dr. Hatfield to ask, you know, how extensive the discussion of risks and benefits was. I'm only relying on -- that it is documented in the medical record.
Q. Let's turn now to paragraph 50 of your expert report. Can you see that?
A. Yes.
Q. Good. And in Paragraph 50, you stated in your report that, "As part of the treatment process for gender dysphoria, patients provide informed consent to their care." And you went on to state that, "However, for gender-affirming medical care, there is the additional safeguard of the assessment by a mental health professional, who in addition to diagnosing gender dysphoria, also assesses capacity to consent and reviews the risks and benefits of treatment with the patient," right?
A. Yes.
Q. So in other words, in any circumstance, patients should provide informed consent to their care. But when it comes to gender-affirming medical care, you look for this additional safeguard of an assessment by a mental health professional, right?
ATTY. GONZALEZ-PAGAN: Objection. Form.
A. Yes.

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Q. (BY ATTY. BEDARD) And part of what that mental health professional would be assessing is the patient's capacity to consent and whether those risks and benefits are adequately understood by the patient, right?
A. Yes. Now, in the case of a minor, the minor is assenting and the parents are giving the informed consent. And so the health professional should be meeting with the patient and parents, in terms of making sure they understand the risks and benefits of the care being provided.
Q. And I'm looking now, Dr. Karasic, at Paragraph 75 of your expert disclosure. Can you see that?
A. Yes.
Q. Now, I just want to make sure I understand what you mean by this first sentence. You said, "No mental health history other than gender dysphoria and seeing a mental health professional before gender-affirming care." What does that mean, exactly?
A. So there was no history, for example, of C. P. being treated with psychiatric medications or -- other than there was mention of, I think in Dr. Hatfield's note, of seeing a mental health person before and being in a group before Dr. Hatfield saw C. P.

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But -- so I said, "seeing a mental health professional," also including Sharon Booker for the assessment for surgery. So that was the extent.
There was an assessment for attention deficit hyperactivity disorder done in 2021. But there had not been any treatment for that. In my --
Q. And other than -- sorry, Dr. Karasic, go ahead.
A. Oh, I said, "in my recollection." That C. P. was not being treated for that at the time of my interview.
Q. Okay. Thank you. So other than the evaluation for ADHD in 2021, is there any record in the medical records you reviewed of C. P. ever meeting with a psychiatrist?
A. No.
Q. Is there any record in the medical records that you reviewed -- any evidence that C. P. met with a psychologist either prior to, during, or after receiving treatment?
A. I don't know Dr. Tutty's -- you know, what Dr. Tutty's PhD was in. So I don't think I can answer that part.
The one set of -- I believe that Sharon -- the letter that I saw, Sharon Booker, is an LCSW.
Q. In other words, Sharon Booker is not a psychiatrist,

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right?
A. Correct.
Q. And Ms. Booker is also not a psychologist, right?
A. Correct.
Q. And what is the LCSW degree? What does that stand for?
A. That's a licensed clinical social worker.
Q. And what does that degree entail?
ATTY. GONZALEZ-PAGAN: Objection. Form.
A. So --
ATTY. GONZALEZ-PAGAN: Outside the scope.
A. So becoming an LCSW means getting a master's degree in social work and then doing many, many hours of supervised work before being able to become licensed. So typically, a licensed clinical social worker is somebody who is a mental health professional. Once they're licensed, they can do that work as a mental health professional independently.
ATTY. BEDARD: Dr. Karasic, I am now going to show you what has been marked as Defendant's Exhibit 5.
(Exhibit 5 marked for identification.)
Q. (BY ATTY. BEDARD) Can you see this exhibit?
A. Yes.

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Q. And I'm going to scroll down just so you can see the entirety of the first page.
A. Okay.
Q. Have you seen this exhibit or this document before?
A. Yes.
Q. And what is it?
A. So the Endocrine Society -- a committee of the Endocrine Society wrote clinical practice guidelines for endocrine treatment of people with gender dysphoria.
Q. Are there different versions of those guidelines?
A. These are the guidelines that I'm familiar with.
Q. What I meant was, you know, with the Standards of Care for WPATH, you've got Version 6, Version 7, Version 8. For the Endocrine Society, are there similar versions?
A. I don't recall whether a committee of the Endocrine Society had done guidelines before this.
Q. But to the best of your knowledge, these are the current guidelines for the Endocrine Society, correct?
A. Yes.
Q. I'm turning now to Page 8 of Exhibit 5. One second. Turning now to Page 15 of Exhibit 5, do you see the -- one second. Okay. Do you see the paragraph

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on Page 8 that begins with, "Because of the psychological"?
A. Yes.
Q. Dr. Karasic, could you read that paragraph for me, please?
A. Yes. "Because of the psychological vulnerability of many individuals with [gender dysphoria or] gender incongruence, it is important that mental health care is available before, during, and sometimes after transitioning. For children and adolescents, a [mental health professional] who has training/expertise in child and adolescent gender development (as well as child and adolescent psychopathology) should make the diagnosis, because assessing GD/gender incongruence in children and adolescents is often extremely complex."
Q. So Dr. Karasic, for the record, you just read a paragraph from the Endocrine Society guidelines. And I'll repeat my question, which was: Do you agree with the statement that you just read?
A. In large part, I would say "yes." I would say that mental health professionals can include kind of primary care providers as well. So the WPATH has kind of moved to having less distinguishing of health professional versus mental health

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professional, in that primary care providers also are providers of mental health care.
Q. Dr. Karasic, did C. P. see a mental health professional who has training or experience in child and adolescent gender development as well as child and adolescent psychopathology, as the guidelines describe, before receiving a diagnosis of gender dysphoria?
ATTY. GONZALEZ-PAGAN: Object to form.
A. Yes, I believe so. Family medicine doctors consider themselves mental health professionals, and if you -- their, like, American Academy of Family Physicians, I think it's called -- their professional organizations make the point that most mental healthcare providers -- most mental health care is provided in primary care settings, and not by psychiatrists.
And so a -- someone in family -- who is board-certified in family medicine has received extensive mental health training. And so we consider family medicine doctors as mental health professionals. And so in that regard, I would say "yes" to your question.
Q. (BY ATTY. BEDARD) Dr. Karasic, based on your review of C. P.'s medical records and your discussion with

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C. P., who diagnosed C. P. with gender dysphoria?
A. So the -- C. P. was diagnosed by Dr. Hatfield, later was diagnosed by Sharon Booker, and I think was diagnosed -- I think may have been charted by Dr. Garza in some other medical records that I saw. But I think the initial diagnosis was from Dr. Hatfield.
Q. And at the time of initial diagnosis by Dr. Hatfield, was C. P. seeing a mental health professional with training and experience in child and adolescent psychopathology?
A. So if -- that was part of my prior answer, that family medicine doctors are considered mental health professionals. They are generalists, but they do have expertise in internal medicine, pediatrics, and psychiatry as part of their training.
Q. Do you know whether Dr. Hatfield, specifically, has training in child and adolescent psychopathology?
A. I would assume that he does, because he's board-certified in family medicine, and -- or I assume he's board-certified in family medicine. But board certification in family medicine includes, as well as board certification in any specialty, requirements of extensive training. And family medicine doctors have that training in working with

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adults and working with children and in providing mental health care.
Q. And Dr. Karasic, did C. P. fulfill DSM-5 diagnostic criteria for gender dysphoria?
A. Yes, I believe so. Remember, I am doing this assessment not at the time that C. P. received these interventions. But it's my opinion that he did have a DSM-5 diagnosis of gender dysphoria.
Q. And what is your opinion based on?
A. So C. P. had had persistent discomfort with his gender role, with how he was perceived by others, and with his body. And that dysphoria had persisted for more than six months. And that the -- that the distress was clinically significant, by -- as described in the DSM.
Q. Is there any other evidence from C. P.'s medical records or from your interview with C. P. that supports your opinion that C. P. fulfilled the DSM-5 diagnostic criteria for gender dysphoria?
A. Yes. I go into greater detail in my summary of my examination of C. P.
Q. And when you refer to the summary of your examination of C. P., you're referring to the section of your expert disclosure that discusses that examination of C. P.?

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A. Yes.
Q. Great. Just wanted to make sure we're on the same page. So in your opinion, Dr. Karasic, was C. P. evaluated by a qualified mental health professional before starting the puberty-blocking medication?
A. Yes.
Q. And who was that?
A. That was Dr. Hatfield.
Q. And was C. P. evaluated by a qualified mental health professional before starting any testosterone treatment?
A. Yes.
Q. And who was that?
A. That was Dr. Hatfield.
ATTY. BEDARD: Okay. I'm going to show you what has been marked as Defendant's Exhibit 7.
(Exhibit 7 marked for identification.)
Q. (BY ATTY. BEDARD) Can you see that document?
A. Yes.
Q. And have you seen these medical records previously?
A. Yes.
Q. I'll be referring throughout the course of this deposition, if I haven't yet, to the numbers that appear either at the bottom middle or bottom right-hand side of the page. Those are referred to

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as Bates numbers. Do you understand what I'm saying when I say "Bates number"?
A. Yes.
Q. Okay, great. So I'm scrolling now to Plaintiff's Bates No. 990.
Have you previously reviewed this medical record?
A. I believe so, yes.
Q. And this is a medical record from Dr. Jeffrey Kyllo with the Polyclinic, right?
A. Yes.
Q. And this specific entry, this specific progress note is dated April 30th of 2019, right?
A. Yes.
Q. I'm scrolling down within that consult note from Dr. Kyllo. It states that C. P. is being referred by Dr. Hatfield for possible top surgery, right?
A. Yes.
Q. And do you see where it says further down in that paragraph, "Has not had mental healthcare counseling at this point"?
A. Yes.
Q. And at this point, C. P. had been taking puberty blockers for several years, right?
A. Yes.

Q. And C. P. had been on some form of testosterone for several years, right?
A. For -- well, for less time than that, for I think over a year. And this says gel at age 11 and injections three months ago.
But one thing I would just distinguish is between mental health counseling, which is psychotherapy, versus having had a mental health assessment. And WPATH make that -- distinguishes those two: A mental health assessment is required by WPATH; but psychotherapy is not required.
Q. So tell me a bit about that distinction. What is the distinction, in your opinion, between mental health counseling and a mental health assessment?
A. Sure. So by "counseling," I might use the word "psychotherapy," because that's in -- certainly in WPATH, makes a distinction between an assessment and psychotherapy. And both in Standards of Care 7 and the upcoming Standards of Care 8, assessments are required, but very specially WPATH says that psychotherapy is not a requirement.
And so the assessment is done by the health professional to make sure that the person has persistent gender dysphoria, typically a diagnosis -- DSM diagnosis of gender dysphoria, and

that they understand the risks and benefits of treatment, and that there's not a mental health or medical condition that stands in the way of their getting a good result from care. So that's all part of the assessment.
Psychotherapy is, you know, is a separate process, though certainly some psychotherapists will do mental health assessments.
Q. And is it your understanding, based on your review of the medical records, that Dr. Kyllo required C. P. to undergo mental healthcare counseling prior to his top surgery?
A. I did not have that impression when I read that. I don't know if there's more to the document than what is said here, but again, there's a distinction between a mental health assessment and mental health counseling, or mental health assessment and psychotherapy. And so, you know, I don't know exactly in this context what the word "counseling" is being used to refer to. But commonly it refers to psychotherapy, which is not a requirement to have surgery.
Q. Dr. Karasic, do you, in your practice, typically recommend psychotherapy for transgender minors who receive top surgery?

A. So it depends on the patient.
Q. It's a sort of case-by-case analysis?
A. Yes.
Q. And what might it depend on? What factors might it depend on?
A. It might depend on whether or not there's co-occurring mental health concerns, and it might depend on whether there is ambivalence, for example, on the part of the patient. So there are -- there are certainly indicators of why psychotherapy might be particularly important.
It -- you know, there are many people who can benefit from psychotherapy anyway, but there's a distinction between, you know, a recommendation or a suggestion and a requirement of psychotherapy before someone is given a letter to a surgeon, supporting surgery.
Q. And Dr. Karasic, do you typically recommend psychotherapy prior to any hormone treatment, including testosterone cream or injections?
ATTY. GONZALEZ-PAGAN: Object to form.
A. It's, again, on a case-by-case basis. Now, I would just say that in my practice as a psychiatrist, I tend to see people who have co-occurred mental illness. And so very often, mental health care is

necessary for co-occurring mental illness.
Q. (BY ATTY. BEDARD) And Dr. Karasic, I appreciate you walking me through the distinction that you've drawn between mental health counseling and a mental health assessment. For the assessment portion of that, which you have said is required by WPATH, does that assessment need to follow certain specific criteria that would be the same in every case? Or is that an individualized assessment?
ATTY. GONZALEZ-PAGAN: Objection. Form.
A. So there are recommendations that are made in trainings, for example, for what should be asked in an assessment. But ultimately, it is obtaining the information that is required for a letter in accordance of Standards of Care 7.
ATTY. BEDARD: Dr. Karasic, I'm now going to show you what has been marked as Defendant's Exhibit 8.
(Exhibit 8 marked for identification.)
Q. (BY ATTY. BEDARD) Can you see this document?
A. Yes.
Q. And do you see that these are records from the Center for Child and Family Therapy?
A. Yes.
Q. Dr. Karasic, I am now on Bates No. Pritchard CFT

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00005 [sic]. Do you see that?
A. Yes.
Q. And this is an intake form from the Center of Child and Family Therapy, correct?
A. Yes.
Q. And did you review this intake form prior to today?
A. I don't recall.
Q. But you reviewed the records for C. P. from the Center of Child and Family Therapy as a whole, prior to forming your expert opinion, right?
A. Yes, that's my recollection.
Q. So halfway through this intake form, do you see the section that says "Reason for Referral"?
A. Yes.
Q. And what was the reason for the referral of C. P. to Ms. Booker?
A. It says, "assessment letter for reconstructive chest surgery."
Q. So in other words, the assessment letter was the purpose of the visit? That's your understanding?
A. Yes.
Q. And then I'm scrolling down to the next page. Do you see where it says, "Treatment Goals"?
A. Yes.
Q. And what are the treatment goals listed?

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A. "Provide an assessment [...] letter for gender affirming reconstructive surgery."
Q. So Dr. Karasic, writing a letter is not a treatment goal, right?
A. Well, it's -- there is -- it is providing an assessment for care, which could be part of a treatment plan, even if it's not -- and I mean, the totality of, you know, of someone's care can be one component, which it sounds like this -- in this particular intake, was focused on that component.
Q. And Dr. Karasic, is it your understanding, based on speaking with C. P. and the review of his records, particularly his records with the Center for Child and Family Therapy, that he had two therapy sessions with Ms. Booker?
A. So yes. My understanding is that there were two sessions for the assessment for surgery.
Q. And after those two sessions, Ms. Booker then wrote a letter of support for his reconstructive surgery?
A. Yes.
Q. Did you review any records showing that Ms. Booker conducted any follow-up assessments after the surgery?
A. I don't recall that from the records. I think the parents might have said something about some involvement that was considered or happened with Sharon Booker afterwards, but I don't recall that from the medical records.
Q. Did you review any records showing that Ms. Booker ever met with C. P. again after the surgery?
A. I did not see any medical records regarding that.
ATTY. BEDARD: All right. Dr. Karasic, I am now going to show you what has been marked as Defendant's Exhibit 9.
(Exhibit 9 marked for identification.)
Q. (BY ATTY. BEDARD) Can you see this document?
A. Yes.
Q. And have you seen this document before today?
A. I believe so, yes.
Q. Did you review this psychological evaluation of C. P. in forming your expert opinion in this case?
A. Yes. I believe I've reviewed it prior to -- right prior to forming my expert opinion.
Q. And for this type of evaluation, for something entitled a "psychologist evaluation," is this something where a physician would typically refer C. P. for this type of evaluation?
A. So my recollection is that this is related to treatment of -- for attention deficit hyperactivity disorder, and very commonly someone does get an evaluation from a psychologist for ADHD prior to initiating treatment.
ATTY. BEDARD: Omar, just as a sidebar, we may be getting some background feedback from you again.
ATTY. GONZALEZ-PAGAN: I apologize. I'm literally on vacation, so the connection is not the best, but I apologize for the feedback.
ATTY. BEDARD: No, that's okay. It's a reverberating sound. I don't know how to describe it.
ATTY. GONZALEZ-PAGAN: I was writing. It's a tiny little desk.
Q. (BY ATTY. BEDARD) Yeah. Okay. So for this type of psychological evaluation, is this the type of evaluation that you might see before someone receives a diagnosis of gender dysphoria as well?
A. My recollection of this evaluation is that it was for attention deficit hyperactivity disorder, ADHD.
Q. Understood. That was the specific purpose for C. P, I think I'm asking, perhaps inartfully, a broader question which is: Is this type of psychological evaluation something that you might see prior to or at the initiation of a diagnosis of gender dysphoria?
A. No, not typically. So a general neuropsychological

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evaluation is not typically what you see prior to care; rather, one might see an assessment that is focused on the care that's being considered.

Q. And Dr. Karasic, I'm going back now to your expert report and paragraph 75, specifically, of that expert report.

A. Yeah.

Q. And in that second sentence of Paragraph 75, you said, "Casey's ADHD diagnosis does not impact the diagnosis of gender dysphoria nor the medical necessity of treatment." What is the basis for that opinion?

A. Sure. So when one is making a diagnosis of gender dysphoria, it's based on the DSM criteria of gender dysphoria. It's based on the symptoms of gender dysphoria. And many people have ADHD. Some people with ADHD also have gender dysphoria. Many do not. Having ADHD does not, you know, mean that you can't also have a diagnosis of gender dysphoria, and indeed, many people have both.

And similarly, if somebody has gender dysphoria, having ADHD does not mean that treatment of gender dysphoria is not medically necessary.

Q. Dr. Karasic, we're at another hour mark, but before we go off the record, I'm hearing what appear to be,

like, instant messaging sounds. Do you have any sort of message system in front of you right now?

A. I do not.

ATTY. GONZALEZ-PAGAN: Stephanie, those may be my computer.

ATTY. BEDARD: Okay. So Omar, I don't know if you're able to turn --

ATTY. GONZALEZ-PAGAN: I'll try to turn them off.

ATTY. BEDARD: Yeah. If you could turn the sounds off, that would be great.

Q. (BY ATTY. BEDARD) And Dr. Karasic, just before we go off the record, have you communicated with anyone during the course of the deposition so far today?

A. Not during the course of the deposition. During the break, Omar called me and said, "You're doing great." And that's pretty much, you know. But during the -- while during -- you know, while we were doing the deposition, I have received no instant messages or any other communication.

Q. Understood. And did plaintiff's counsel say anything to you during the break other than, "You're doing great?"

A. I think he said maybe something to the effect of, "You're doing great. Remember just answer the

questions." So kind of typical lawyer reinforcement.

Q. Did he say anything else?

A. He did not say anything else, and I didn't say anything as well. It was a, you know, extremely brief communication during the break.

Q. Did you discuss any documents when you were speaking with plaintiff's counsel?

A. No.

ATTY. BEDARD: Okay. If we want to take a short break, it's two -- sorry -- 11:03 Pacific. Do you want to come back at 11:10?

ATTY. GONZALEZ-PAGAN: That works.

THE VIDEOGRAPHER: We are going off the record at 11:04.

(Break from 11:04 a.m. to 11:13 a.m.)

THE VIDEOGRAPHER: We are back on the record at 11:13.

Q. (BY ATTY. BEDARD) Dr. Karasic, we've just taken a short break. Did you speak with anyone during the break?

A. No.

Q. Did you communicate with anyone via phone or email?

A. No.

ATTY. GONZALEZ-PAGAN: Objection to form.

A. No.

Q. (BY ATTY. BEDARD) Did you review any documents during the break?

A. No.

Q. Let's turn now to -- back to Exhibit 2, your expert disclosure. And I'm looking specifically at paragraphs 38 and 39. Can you see that document?

A. Yes.

Q. So in Paragraphs 38 and 39 of your report, you discuss the reversibility or the irreversibility of treatment. So Dr. Karasic, is it your expert opinion that certain gender-related treatment are reversible and others are irreversible?

A. Yes.

Q. So let's talk about that for a minute and sort of go through some of these different procedures.

So first, for puberty blocking, is it your understanding that puberty -- the impact of puberty blockers is reversible?

A. Yes.

ATTY. GONZALEZ-PAGAN: Objection to form.

A. Yes.

Q. (BY ATTY. BEDARD) And in your report, you stated that "once stopped, a patient immediately returns to the stage of pubertal development that had begun

when the treatment was initiated"; is that right?
A. Yes.
Q. So just so I understand this -- if a patient goes on puberty blockers, do they immediately start puberty again once they go off the blockers, or is there typically a period of time before puberty would start again?
ATTY. GONZALEZ-PAGAN: Objection to form.
A. Well, if -- if they go off puberty blockers, then they can then have initiation of production of hormones that can start the changes of puberty that, you know, would have happened if puberty had not been paused by the puberty blockers.
Q. (BY ATTY. BEDARD) Understood. But I guess what I'm asking is if a patient goes off puberty blockers -- to the extent we know, if a patient goes off puberty blockers, is there typically a delay before that patient would begin puberty again?
A. Well, they've already begun puberty, in that puberty blockers are started at Tanner Stage II. So presumably, they would again be at -- when puberty blockers are discontinued, they would be at Tanner Stage II. And then with their own production of sex hormones, they could then progress in puberty.
Q. So let me ask it a slightly different way, then.

Let's say a patient goes onto puberty blockers and then goes back off those puberty blockers. You testified that it is a reversible treatment, and the patient will immediately go back to where they started. What I'm trying to understand is, is it an immediate process? So if someone goes off of puberty blockers, will they immediately restart where they previously left off in their puberty development? Or does it typically take some time for puberty to restart?
ATTY. GONZALEZ-PAGAN: Objection to form.
A. So puberty is a process of development. And so the -- but the development of puberty can continue again once the person has stopped puberty blockers. There's certainly data -- you know, more data, people starting and stopping puberty blockers, from the treatment of central precocious puberty, in which case people are on puberty blockers to delay puberty so that the patient undergoes puberty with their peers, and so when they have reached that time, they're taken off puberty blockers, and then they can proceed in puberty with their peers.
But of course, any development that they've had before starting puberty blockers, you know, could still be there.

Q. (BY ATTY. BEDARD) And then in your report, you also discussed how certain treatments are irreversible. And which treatment would you consider to be irreversible?
A. Well, WPATH labels partially reversible and reversible treatments. And hormones are -- can be partially reversible, up to a point, in that somebody who stops hormones could then -- for example, if someone stopped puberty blockers and hormones, could then proceed in puberty of their sex assigned at birth, but they may have some changes related to -- relating to having been on cross-sex hormones.
And then surgery being mostly irreversible, you know, there can be some attempts to reverse the cosmetic result with chest surgery. Certainly, genital surgery is irreversible.
Q. And a minute ago, Dr. Karasic, you mentioned Tanner Stage II. So what is Tanner staging?
A. So Tanner staging is a I-to-V scale relating to puberty, where Tanner Stage II is the start of puberty, and people assigned female at birth, that the development of breast buds is usually the indicator. And Tanner Stage V is having completed puberty. So pediatricians and pediatric

endocrinologists stage where people are in puberty on that I-to-V scale.
Q. And what was the Tanner stage of C. P. at the initial presentation to Dr. Hatfield?
A. So because Casey -- so I did not examine Casey at that time, but Casey had reported the very earliest breast development, and -- around that time. And so with -- even though I saw somewhere in the medical records, and I don't know, but from Casey's report, there was -- it sounded like breast bud development, which would have been Tanner Stage II, as Casey started to have some discomfort with development in his chest.
Q. And was there some discrepancy you're referencing in the medical records about the progression of breast development?
A. Yeah. There was somewhere, I think, where breast -- where it may have said no breast buds. I can't remember where that was in the medical record. But clearly the impetus, as described by Casey, for going to the doctor was starting to have these changes.
And when you start to have those changes, breast bud development specifically, that puts you in Tanner Stage II. Before that, Casey did not

have, you know, discomfort with his chest.
Q. And for someone who starts taking puberty blockers at Tanner Stage II, are they considered to be fertile or infertile at that point?
A. So --
ATTY. GONZALEZ-PAGAN: Objection to form.
A. So my understanding is that fertility develops with the progression of puberty, that there has been concern about fertility if you, you know, if somebody halts at Tanner Stage II, but really only if they're going on to cross-sex hormones. If somebody stops puberty blockers, they just continue progressing in puberty. And when we look at people with central precocious puberty, they still have fertility, you know, after they have gone off of puberty blockers.
Q. (BY ATTY. BEDARD) And just in layman's terms for myself, when we talk about central precocious puberty, is that when someone starts undergoing puberty at an earlier age than their peers, and takes a puberty blocker?
A. Yes.
Q. Okay. So you mentioned a second ago the impact on fertility of taking some sort of hormone treatment like testosterone. So is someone who presents at

Tanner Stage II and starts taking puberty blockers and then goes on to take testosterone, are they considered fertile at that point?
A. So my understanding is that fertility can persist if somebody has gone a little bit further into puberty. But I also know that there have been trans men who have been told they were not going to be fertile who later had babies. And so, you know, it may be a determination of how far into puberty it's required for them to, you know, to be fertile.
But there certainly is counseling of people if they start puberty blockers, you know, early, that if then they continue in transition, that that might affect their -- you know, with hormonal transition, that might affect their fertility.
Q. Okay. So in other words, when someone is about to take puberty blockers, you would advise that there be an informed consent process about the potential impacts on fertility?
A. Yes.
Q. And the same would be true for hormone treatment like testosterone, that there should be a process of informed consent about that treatment and the impacts on fertility?
A. Yes.

Q. And you mentioned that there have been some concerns in the medical and scientific community about the impact on fertility. Can you talk a little bit more about that?
ATTY. GONZALEZ-PAGAN: Objection to form.
A. So just that if -- that the patient and their parents are well informed that this course of treatment of puberty blockers that are not halted but then progressing on to cross-sex hormones, that that may affect the person's fertility. And so it's important for the provider to have a discussion with the patient and parents.
Q. (BY ATTY. BEDARD) Dr. Karasic, I am now going to show you what has been marked -- reshow you what has previously been marked as Defendant's Exhibit 5.
Do you see the Paragraph -- I'm sorry, let me back up.
This is what has previously been marked as Defendant's Exhibit 5, and it is the 2017 Endocrine Society guidelines. Do you understand that?
A. Yes.
Q. Okay. And do you see the section on Page 11 that starts with "Remarks"?
A. Yes.
Q. Okay. Could you read that paragraph, please -- that

first paragraph after "Remarks"?
A. "Persons considering hormone use for gender affirmation need adequate information about this treatment in general and about fertility effects of hormone treatment in particular to make an informed and balanced decision. Because young adolescents may not feel qualified to make decisions about fertility and may not fully understand the potential effects of hormone interventions, informed consent and protocol education should include parents, the referring [mental health professionals], and other members of the adolescent's support group. To our knowledge, there are no formally evaluated decision aids available to assist in the discussion and decision regarding the future fertility of adolescents or adults beginning gender-affirming treatment."
Q. Do you agree with that statement, Dr. Karasic?
A. Yes.
Q. And do you agree specifically with the portion of this statement from the Endocrine Society that says "consent and protocol education should include parents as well as the referring [mental health professionals]"?
A. Yes.

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Q. Based on your review of the medical records and your discussion with C. P., did Dr. Hatfield include a referring mental health provider in his discussion and decision-making about fertility with C. P.?
ATTY. GONZALEZ-PAGAN: Object to form.
A. Dr. Hatfield was the referring mental health provider.
Q. (BY ATTY. BEDARD) So let me ask it a different way, then: Did you see any discussion or any evidence in the medical records, that Dr. Hatfield discussed the impacts on fertility of starting puberty blockers?
A. Yes. It's my recollection that there was documentation that there was a discussion about fertility.
ATTY. BEDARD: Let me pull up those records for you.
(Exhibit 10 marked for identification.)
Q. (BY ATTY. BEDARD) So Dr. Karasic, can you see the document that says, "CERTIFICATION OF THE AGENT FOR THE CUSTODIAN OF RECORDS"?
A. Yes.
Q. And these are the documents -- the medical records from the Polyclinic that you previously reviewed for C. P.?
A. Well, I can only see the little top part of it, but

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I'm assuming --
Q. Let me scroll down a bit.
A. Okay. Yes, that looks like the documents -- part of the documents that I reviewed.
Q. Do you recall where specifically in these medical records Dr. Hatfield discussed the impacts on fertility with C. P. and his parents?
A. No. And I don't remember whether it was in notes from Dr. Hatfield or with Dr. Garza. I just, you know, I've reviewed these a while back, but my recollection was somewhere there was a charting of a fertility discussion. And that's just my recollection.
Q. Do you recall anything else about that discussion?
A. No. I was not present for the discussion, so I can't really say anything about it --
Q. Understood.
A. -- except the records that you have as well.
Q. And in your conversation with C. P. in March of this year, did you discuss with him whether there had been a prior discussion with any of his providers about the impact on fertility?
A. Yes. And C. P. had specifically said that he had no interest in bearing children. And so that he had had that discussion with his providers, and his

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position was that he had no interest in ever bearing children.
Q. Dr. Karasic, what are the effects of puberty blockers on bone density?
A. So the data on that are really a mixed bag. There is concern if someone is on puberty blockers for too long that that can affect bone density. But overall, bone density data on young people is kind of mixed. There was some data I recall reading that people assigned male at birth who were transgender had lower bone density before starting puberty blockers. Perhaps they were less physically active than their cisgender peers.
So there is concern with bone density, and particularly concern if people are on puberty blockers for a very long time. And there's concern in adults for people who have hormone-blocking without cross-sex hormones.
But when -- the long-range data that there's been, like the Dutch have followed people over ten years and concluded that there are transgender people -- patients who receive cross-sex hormones -- presumably some have had puberty blockers first -- that they had -- that there was no effect that they saw in the ten-year period on bone density.

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So there have been some reports of effects, but I think that the general consensus is that then if people are moving on to cross-sex hormones, that that is not a long-range -- a long-term problem for them.
Q. Okay. So to make sure I understand that, the concern, at least in part, might stem from someone who is on a puberty blocker for a long time that does not then start cross-sex hormones, right?
A. Yes.
Q. But the initiation of cross-sex hormones means that the treatment at that point becomes at least partially irreversible, right?
ATTY. GONZALEZ-PAGAN: Objection to form.
A. At least partially, yes.
Q. (BY ATTY. BEDARD) So any impact on bone density that occurred on puberty blockers alone is not something that could then be reversed; is that right?
ATTY. GONZALEZ-PAGAN: Objection.
A. No, that's not true. Because first of all, the data about bone density and development, is kind of all over the place. And then people given cross-sex hormones, and it appears that their bone density is stable in long-term follow-ups on cross-sex hormones.

And so while there's concern in that, you know, it might be listed as a potential side effect in given informed consent, and there are concerns some people have had in reviewing some data; in fact the data is kind of all over the place, and the long-term impact on transgender people is, at least according to the Dutch, that study of long-term -- that there is not an impact of, you know, long-term cross-sex hormones on bone health.

Q. (BY ATTY. BEDARD) Which is the Dutch study? Who were the authors of that study?

A. So there were a couple studies where the first author -- so it was a big Dutch group. It was Wiepjes. Wiepjes, W-i-e-p-j-e-s, was the author of a couple of articles about a long-term follow-up on bone health in patients who have transitioned in Holland.

Q. And have those studies focused on the impact of minors taking puberty blockers?

A. No. Those were focused on impact in adults. And at least Wiepjes's. I don't think -- I think there's maybe a little bit of data that the Dutch might be publishing at some point on the group that went through puberty blockers and then hormones and then surgery. And perhaps that will include bone health.

But I think Wiepjes looked at, like, ten years of hormone treatment in adults.

Q. So what data is out there, then, about the impact of puberty blockers on minors in terms of the impacts on bone density?

A. So I don't think I can provide you with a literature review of it. I can say my impressions and, you know, maybe having looked at reviews, that different people who have looked at it maybe have had somewhat different results in terms of effect on bone density; and that people who then progressed to cross-sex hormones or, you know, presumably if people stop cross-sex hormones and they get their -- the hormones from the sex they were assigned at birth, that they have healthy bones.

The one thing I saw -- I think it was from Wiepjes's, like, perhaps in -- trans women over 50 have bone health issues similar to cisgender women over 50, as opposed to cisgender men over 50. But, like, fracture rates were similar to cisgender women. And before that, I think there was not a difference. Yes.

Q. So switching gears slightly. So when a minor starts taking a puberty blocker, do we know the long-term impacts on brain development?

A. So we certainly have experience with, you know, with trans people who have had puberty blockers, as well as cisgendered people who have puberty blockers. But, you know, certainly more research, you know, is something that I think, you know, could happen.

The issue is that people are on puberty blockers typically for just a short period of time, and so it might be even difficult to, you know, to kind of measure, because then they're moving on to cross-sex hormones.

Q. Okay. But to make sure I understand that, at least in this case for C. P., C. P. first had a Vantas implant and then actually received a second Vantas implant, right? So the puberty blockers actually continued throughout the course of the hormone treatment as well. It's not something that stopped when hormone treatment began, right?

A. That's true. There's often overlap. And -- but I think when -- once somebody is receiving cross-sex hormones, once C. P. was receiving testosterone, C. P. was having the influence of testosterone on development. And so the fact that estrogen was being suppressed was not maybe as much of a, you know, concern, in that people assigned male at birth have predominantly testosterone and lower amounts of

estrogen in their system during puberty.

Q. So I have a similar question about a different effect: If a minor starts taking a puberty blocker, do we know the long-term impacts on body composition -- body fat composition, I should say?

A. So I don't know -- I don't think I could tell you the studies on body fat composition, you know, for people on puberty blockers. Certainly if people -- if somebody gets -- if somebody's assigned female at birth, and then they start on testosterone later, after starting on testosterone, they can have both a building of muscle and a redistribution of fat that could affect body fat content.

Q. Dr. Karasic, I'm going to show you again Defendant's Exhibit 5.

Can you see that screen?

A. Yes.

Q. And we are, again, looking at the 2017 Endocrine Society guidelines, right?

A. Yes.

Q. Okay. On Page 3 of the Endocrine Society guidelines, do you see the paragraph that's marked 2.4 -- Paragraph 2.4?

A. Yes.

Q. Okay. Could you read that paragraph, please?

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A. "In adolescents who request sex hormone treatment (given that this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16."

Q. Dr. Karasic, do you agree with that statement?

A. Well, I am a psychiatrist and not an endocrinologist, but this is my understanding of the, you know, consensus of the endocrinologists who wrote this statement.

Q. Based on your review of C. P.'s medical records and your conversation with C. P., did Dr. Hatfield follow this guideline and include a multidisciplinary team of medical and MHPs to confirm the persistence of gender incongruence and sufficient mental capacity to give informed consent?

A. So it's been a little while since I've reviewed the entire guidelines, but I believe elsewhere they say -- they speak to a preference for a multidisciplinary team, but also recognize that multidisciplinary teams are not always available. And I think it speaks to a difference between

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the European gender clinics and, to some extent, perhaps academic medical centers that have gender teams in the US. But in the US, most transgender care is provided in private practice settings, and there is no multidisciplinary team present. There can be referrals to people from other disciplines, but just health care is structured a little bit differently than in the European gender clinics.

Q. Was C. P. 16 years or older at the time of providing consent to testosterone therapy?

A. No. But remember, C. P.'s parents consented and C. P. assented.

Q. Was C. P. 16 years or older at the time of providing consent for the bilateral mastectomy surgery?

A. No.

Q. What is the grading of evidence for a reference range of 320 to 1000 MGDLs for testosterone for trans males in the Endocrine Society guidelines?

A. Well, I would ask you to repeat your question, but I don't really think that it's my place to be reciting back what's in the endocrine guidelines.

Q. Are you aware of the grading of evidence?

A. There is a grading of evidence. You were asking for a specific grade on a specific question within that and asking if I know that off the top of my head,

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and so my answer would be "no."

Q. And do you know the grading of evidence for a mastectomy procedure for adolescent trans males in the ESG?

A. I can't tell you what the grades given in the Endocrine Society guidelines.

Q. And do you believe, in your opinion, that an 11-year-old would have the capacity and maturity and judgment to understand what it is like to be sterilized as an adult?

ATTY. GONZALEZ-PAGAN: Object to form.

A. So remember that the parents are providing consent certainly with the assent of the minor, and with discussion of the rest of the team. But I would also say that starting a puberty blocker at age 11 isn't in and of itself sterilizing.

It could be sterilizing if somebody were transitioning further. But an 11-year-old could start puberty blockers and then go off of puberty blockers and still be fertile.

Q. (BY ATTY. BEDARD) So thinking more about this informed consent for a mastectomy in particular, would a proper informed consent form for that surgical procedure contain a warning that a patient is likely to lose the ability to breast-feed?

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A. So I don't know what might be on a given form, but I think that, you know, it's reasonable for that to be part of a discussion of anyone who has a mastectomy, whether they're transgender or cisgender. You know, just that they know that they, you know, may very well not be able to breast-feed, whether that's a cisgender woman who is having a mastectomy for, you know, for whatever medical reason, or a transgender person.

Q. But in other words, you would recommend, in your professional judgment, that an informed consent form for a mastectomy, regardless of the circumstances, should include information that the patient is likely to lose the ability to breast-feed, right?

ATTY. GONZALEZ-PAGAN: Objection. Mischaracterizes testimony.

A. Yeah. I think I said in my testimony I don't know about construction of a form, but I think that should be part of the discussion in informed consent, you know, making clear that the person, you know, won't be able to breast-feed.

In the case of C. P., C. P. was very clear that he never wanted to parent. And even now, as an older teen, continues to be very clear about that. And I doubt he would be breast-feeding anyone else's

baby.
And so in this case, you know, it should be part of the discussion, but it's not necessarily, you know, a kind of a deal-breaker for an individual patient if they're not thinking of parenting. And, you know, of course people can parent and feed their infants in other ways.
ATTY. BEDARD: Dr. Karasic, I am going to show you what has previously been marked as Defendant's Exhibit 3. And these are the Polyclinic records that were recently produced to us and then produced to plaintiffs.
Q. (BY ATTY. BEDARD) And I'm going to scroll in, because I can see you squinting here. I don't want you to have to do that. Can you see that okay?
A. Yes.
Q. Okay. And this is the page we previously discussed. That is C. P.'s informed consent for his bilateral mastectomy, correct?
A. Yes.
Q. Okay. I'm going to scroll down to the different provisions in the consent form. And let me know when you want me to keep scrolling so that you've been able to review the entire form.
A. Okay. Okay. Yeah, I can only see down to Line 6,

so if you could scroll up after that.
Q. Sure.
A. Okay. I've read it.
Q. Okay. Was C. P. informed, prior to the bilateral mastectomy, that he would lose the ability to breast-feed?
A. So one can't tell from the form. This was a form that was signed, but it does not necessarily say everything that was part of a discussion. C. P. did have a discussion with Sharon Booker and presumably with Dr. Hatfield. And so hopefully there, you know, was a thorough discussion of the risks and benefits of surgery, but not everything is listed on this form.
Q. So Dr. Karasic, I hear you saying "hopefully" that those conversations took place.
A. Mm-hmm.
Q. But is there any evidence in the medical records themselves that any of C. P.'s providers discussed the impact on C. P.'s ability to breast-feed?
A. I don't recall. When I talked with C. P. about -- C. P. and C. P.'s parents had said that there was a thorough discussion of risks and benefits of the treatments they received, but I don't recall whether there was documentation elsewhere in the medical

record of that.
And given that C. P. was -- has been pretty emphatic from early on about never wanting to bear children, my guess is that there wasn't -- it was not, you know -- I would say hopefully it was discussed, but it was not, you know, a consideration by C. P. or C. P.'s parents in making the decision.
Q. And at the bottom of the page here for this consent form for the bilateral mastectomy, do you see the date is December 10th of 2019?
A. Yes.
Q. And C. P. was 14 years old at that point in time, right?
A. Yes. About three months, I think, before becoming 15.
Q. So at age 14, C. P. signed the consent form for the mastectomy procedure, right?
A. And one of C. P.'s parents.
Q. Signed as a witness, right?
A. Well, that's how this particular -- it looks like this is a form that was -- the one that was signed may well have been one meant for adults, because the parent is not just a witness when there's consent for any care by a minor.
So the, you know, the form does say "Witness

Signature," but in fact, the informed consent was really being given by the parent.
Q. And Dr. Karasic, have you seen any evidence in the medical records that C. P. was evaluated to ensure that there was capacity to make fully informed decisions and specifically to consent to surgical treatment?
A. So that, I don't recall. But remember, the consent is being given by the parent. And the minor is -- is assenting. And so they should have an understanding of what's happening, but the informed consent is being given by the adult parent.
Q. So I understand that typically a minor would be assenting and the parent would be consenting. But as we sit here looking at this consent form, Casey -- sorry, C. P., the minor, is the one who actually signed the form on the patient signature line, right?
A. Well, you have the same form that, you know, you're showing me the form. I see where it was signed. But I think they just used a form to be signed that was a stock form for adults, I assume, because it says "patient" and "witness." If this was a form that was meant for minors, it's not a well-constructed form, because the consent is -- the

informed consent is done by the parent and the patient assents. And if the form was constructed some other way, it's not the best, you know, constructed form.

Q. So Dr. Karasic, we're about at that hour mark again. Do you want to keep going? Do you want to keep plugging away? Would you prefer to take a break? What's your preference?

A. Well, how many more hours are you guessing this is going to be?

ATTY. GONZALEZ-PAGAN: Can we go off the record, Stephanie, just to discuss?

ATTY. BEDARD: Sure. That's fine.

THE VIDEOGRAPHER: We're going off the record at 12:03.

(Break from 12:03 p.m. to 12:47 p.m.)

THE VIDEOGRAPHER: We are back on the record at 12:47.

Q. (BY ATTY. BEDARD) Great. Dr. Karasic, did you speak with anyone during the break?

A. No.

Q. And did you review any documents during the break?

A. No.

Q. All right. So I'm going to show you what has been marked as Defendant's Exhibit 10. Can you see that

document?

A. Yes.

Q. Great. And just as a refresher, Defendant's Exhibit 10 are the records from the Polyclinic that we previously discussed during your deposition. So I'm turning now to Bates No. 13.

So Dr. Karasic, do you see the progress note in the middle of the page from Dr. Hatfield from June 9th of 2018?

A. Yes.

Q. And it appears from this progress note that Dr. Hatfield had tested C. P.'s testosterone levels, right?

A. Yes.

Q. After undertaking that test, did he prescribe any medication for C. P.?

A. It looks like from the note, yes.

Q. And what was that medication?

A. Well, it looks like it was a testosterone cream. And he also said, "We will also include a small amount of estradiol to improve bone growth."

Q. And what is your understanding of why estradiol would be prescribed in these circumstances?

A. So I don't think I can comment on that. I'm a psychiatrist, and I wasn't -- also wasn't the person

making that decision. So perhaps better to ask Dr. Hatfield.

Q. Understood. So let me try to ask it a different way. What hormone is primarily responsible for the growth of breast tissue?

A. So breast tissue is primarily a response to estrogen.

Q. Okay. And what hormone, then, is important for ensuring things like normal bone growth and bone density that we previously discussed?

ATTY. GONZALEZ-PAGAN: Objection. Form.

A. So both testosterone and estradiol can support bone health.

Q. (BY ATTY. BEDARD) And am I correct in understanding that testosterone is converted into estradiol in the bone?

A. I'm not -- I don't think I'm going to extend my expertise into the effects -- the relative effects of estradiol and testosterone on bone health and bone growth.

Q. Okay. So you are not offering any opinion in this case on any testosterone levels that C. P. may have had?

ATTY. GONZALEZ-PAGAN: Objection. Form.

A. I'm not offering expertise in this case on the

proper approach, hormonally, related to bone growth.

Q. (BY ATTY. BEDARD) Well, I guess I'm asking a slightly different question: Are you offering an opinion in this case as to whether the medications provided to C. P. were appropriate under his specific circumstances?

A. Yes.

Q. Okay. So are lab reference ranges important for a physician to use to determine if a lab value is normal or abnormal?

ATTY. GONZALEZ-PAGAN: Objection. Form.

A. Yes. Lab values are important, and also clinical effect.

Q. (BY ATTY. BEDARD) And do lab ranges differ for males and females?

A. Yes.

Q. And does a person's gender identity change what's the normal range of their lab values?

A. In one regard, which is when people have transitioned. And certainly I know in adults who have transitioned, there are target ranges by their primary care physicians of bringing hormones into -- within the target range of the gender to which they identify, as opposed to the sex assigned at birth.

Q. And can erythrocytosis -- am I pronouncing it

correctly if I say "erythrocytosis," Dr. Karasic?
ATTY. GONZALEZ-PAGAN: Stephanie, I apologize, you spoke fairly quickly there, and I was having a hard time understanding you. So I don't know -- at least for my edification, I couldn't understand what you just asked.
ATTY. BEDARD: Sure.
Q. (BY ATTY. BEDARD) Let me ask it this way: Dr. Karasic, what is the medical term for someone with a high red blood cell count?
A. Oh, okay. So you were -- it sounds like you were referring to erythrocytosis when you were asking -- I think that's the word that you were using?
Q. It is, yes. I just wanted to make sure I was pronouncing it correctly.
A. Yeah, okay.
Q. So erythrocytosis?
A. Yes.
Q. Okay. So can erythrocytosis be dangerous to a patient?
A. Yes. If somebody has, like, a polycythemia -- if somebody has a really high red blood cell count, that can be harmful.
Q. And can testosterone cause erythrocytosis?
A. So yeah, it can cause polycythemia, I think is how

they would refer to it. But yes, testosterone can cause an increase in red blood cell count, and that has risk.
Q. And are you aware that in the Framington [sic] study, the younger female group hematocrit levels above 45 had an increased risk of cardiovascular disease, myocardial infection, and death?
ATTY. GONZALEZ-PAGAN: Objection. Lack of foundation.
A. Yeah, I am not aware of the details of the Framingham study, in terms of red blood cell count. I guess I'll leave it at that.
Q. (BY ATTY. BEDARD) If a patient does develop erythrocytosis, should the amount of testosterone given to that patient be decreased?
A. It depends in -- at least where I've seen it happen has been in adult patients, and usually the recommendation is to give blood regularly. And that brings it down to the normal range.
Q. So turning back now to Exhibit 10. I'm looking now at the lab notes at the top of the page. Do you see where it says 45.5 percent?
A. Yes.
Q. And is it your understanding that the normal reference range is between 35 to 44 percent?

A. Well, the reference range from this lab on the result says 37.5 to 51. So I think the reference range can vary by lab.
Q. What's your understanding of the normal reference range?
A. Somewhere around that. I think there's a different -- slightly different reference range for -- for men and women. And -- but yeah, I guess I would...
Q. And are you aware of the condition known as polycystic ovarian syndrome, or PCOS?
A. Yes.
Q. And is it your understanding that PCOS has been associated with things like insulin resistance or metabolic syndromes or diabetes?
ATTY. GONZALEZ-PAGAN: Objection to form.
A. Yes.
Q. (BY ATTY. BEDARD) And would it be important for a physician to help a patient with PCOS lower their testosterone levels to prevent those complications?
A. I don't think I'm going to comment as an expert on the best treatments of PCOS.
Q. One second, Dr. Karasic. Okay.
Dr. Karasic, are you aware that in 2019, the Centers for Medicare and Medicaid Services issued a

decision memo on gender dysphoria and gender reassignment surgery?
A. What year did you say?
Q. 2019.
A. That the -- that CMS -- well, CMS has made a few statements. So you might need to show me which one that is in 2019. I know that they made a statement in 2015.
ATTY. BEDARD: Sure. Let's take a look at it. So I'm showing you what has been marked as Defendant's Exhibit 11.
(Exhibit 11 marked for identification.)
Q. (BY ATTY. BEDARD) Can you see this document?
A. Yes. Yeah, I believe this was --
Q. And all --
A. I believe this was 2015 that this decision was made.
Q. Oh, you know what? Thank you, Dr. Karasic. The date on here is August 30th of 2016. Do you see that?
A. Oh, okay. 2016, I'm sorry.
Q. We were both wrong, so. You were closer than I was.
A. Yeah.
Q. So now that we know we're talking about the same document here, have you seen this same document previously?

A. Yes.
Q. Okay. And you've had the opportunity to previously review it?
A. Not lately.
Q. So I'm going to go down to the Decision section of this exhibit. And do you see where it says section "IX. Decision"?
A. Yes.
Q. Okay. Could you please, Dr. Karasic, read the first full paragraph, starting with "Currently"?
A. "Currently, the local Medicare Administrative Contractors determine coverage of gender reassignment surgery on a case-by-case basis. We have received a complete, formal request to make a national coverage determination on surgical remedies for gender identity disorder (GID), now known as gender dysphoria. The Centers for Medicare & Medicaid Services (CMS) is not issuing a National Coverage Determination (NCD) at this time on gender reassignment surgery for Medicare beneficiaries with gender dysphoria because the clinical evidence is inconclusive for the Medicare population."
Q. And what's your response to that statement, that the clinical evidence is inconclusive?
A. Yes. So I remembered it -- yeah, now it would

be 2016, actually -- because I was part of a group that responded when this came out. We were at the WPATH conference in Amsterdam in 2016 when it came out and we disagreed. Of note, the CMS had lifted the categorical exclusion transgender care two years earlier, in 2014.

In this statement, they say that clinical evidence is inconclusive for the Medicare population, which is primarily the elderly, but also disabled -- some disabled people. And indeed, there was not a lot of research on people with Medicare, because people with Medicare had difficulty accessing surgery at this time.

So I do think that within that paragraph, noting that they're talking about Medicare beneficiaries -- which are specifically the elderly and some disabled people. Whereas they had, two years earlier, lifted the CMS exclusion overall on payment, they were asking to do this on a -- continue doing it on a case-by-case basis for now while more information is gathered on -- for gender-affirming surgery in people on Medicare.

Q. Let's look for a second, then, at the studies referenced in this decision.
A. Mm-hmm.

Q. I'm looking now at the section of this decision memo titled "Quality of Studies Reviewed." And let's look now at the second full paragraph discussing the studies reviewed. Could you read that paragraph for me that starts with "Of the 33 studies reviewed"?
A. Okay. "Of the 33rd studies reviewed, published results were conflicting -- some were positive; [some] were negative. Collectively, the evidence is inconclusive for the Medicare population. The majority of studies were non-longitudinal, exploratory type studies (i.e. in a preliminary state of investigation or hypothesis generating), or did not include concurrent controls or testing prior to and after surgery. Several reported positive results but the potential issues noted (...) reduced strength and confidence. After careful assessment, we identified six studies that could provide useful information. Of these, the four best designed and conducted studies that assessed quality of life before and after surgery using validated (albeit non-specific) psychometric studies did not demonstrate clinically significant changes or differences in psychometric test results after GRS."
Q. Thank you, Dr. Karasic. So while I understand you were saying that CMS's decision is specific to the

Medicare population, at least this specific decision, the concerns voiced in this paragraph don't have to do with the fact that the studies were related or were not related to Medicare, right?
ATTY. GONZALEZ-PAGAN: Objection. Mischaracterizes the document.
A. It says "collectively the evidence is inconclusive for the Medicare population." And you know, because until two years earlier there was a specific exclusion of paying for transgender care in the Medicare population, it wouldn't have been possible for there to be studies of that.

However, some of the studies they cite are from other countries. And since then, there have been more studies about effects of gender-affirming care. And so I wouldn't say that these -- the studies they cite are the totality of evidence.

I would also say that the differences in psychometric test results, I would certainly have to look at each study to see what they meant by that, but there has been evidence of people having improved body image, less gender dysphoria, and less depression, less suicidality in a number of studies since then. So I wouldn't say this is an exhaustive review of the studies in that regard.

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Q. (BY ATTY. BEDARD) And Dr. Karasic, do you reference this CMS decision memo in your report?
A. No. It's not original research. It was, you know, some members of the CMS staff, not people involved in transgender care, who had come up with this. And there was some communication between our group and theirs. But it was not original research, it was one, you know, review that was focused on the Medicare population at that time in 2016.
ATTY. BEDARD: Dr. Karasic, I'm now going to show you what has been marked as Defendant's Exhibit 12.
(Exhibit 12 marked for identification.)
Q. (BY ATTY. BEDARD) Can you see that document?
A. Yes.
Q. And have you seen this document before?
A. Yes.
Q. What is this document?
A. This is a document, it says, by the Counsel for Choices in Health Care in Finland.
Q. And what is your understanding of the Counsel for Choices in Health Care in Finland?
A. It's a committee in Finland.
Q. And did that committee adopt a recommendation on treatment methods for gender dysphoria for minors?

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A. My understanding -- and I guess from reading the full document as well -- that they had -- that they did make some recommendations.
Q. Okay. Well, I'm going to scroll down here and ask you to read the second-to-last paragraph, beginning with "Surgical treatments."
A. Yes. Now, I don't know in this case --
Q. If you could actually read it for the record, that would be great.
A. Okay. "Surgical treatments are not part of the treatment methods for dysphoria caused by gender-related conflicts in minors. The initiation and monitoring, like, of hormonal treatments must be centralized at the research clinics on gender identity at HUS and TAYS.
"Research data" -- do you want the remainder? -- "Research data on the treatment of gender dysphoria due to gender identity conflicts in minors is limited. COHERE considers that, moving forward, multi-professional clinics specializing in the diagnostics and treatment of gender identity conflicts at HUS and TAYS should collect extensive information on the diagnostic process and the effects of different treatment methods on the mental wellbeing, social capacity and quality of life of children and youth. There is also a need for more information on the disadvantages of procedures and on people who regret them."
Q. Dr. Karasic, what is your response to this recommendation by COHERE Finland?
A. You know, health care across the world is diverse, and different places take different approaches. I know that in the wake of some maybe controversies and like Bell v. Tavistock in the UK, that there was questioning of care for minors. And that -- and this Finish committee seems to be responding to that. But it also is -- it's just one committee's response.
Q. Would you agree that research data on the treatment dysphoria due to gender identity conflicts in minors is limited?
A. I think that there's -- there is quite a bit of data, and so it just depends how one defines "limited." Always great to have more data, but we also do have a substantial amount of information, not only from studies, but from many decades of minors receiving gender-affirming care.
Q. Would you agree that there is a need for more information on the disadvantages of procedures and on people who regret them?

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A. Well, we have a lot of information showing very little regret. It's, of course, always good to have more information. I cite in my report a study by Bustos of several thousand -- a review of several thousand cases within various studies, showing a regret rate of about 1 percent.
Kaiser of Northern California reviewed recently all of its cases of chest surgery in transmasculine youth since 2013, and there were two cases of regret out of, I think, just over 200 surgeries that they've done. So about 1 percent.
So we know that regret exists, and it's good for us to have more knowledge about regret. But we also know that it is relatively uncommon.
Q. Dr. Karasic, this report from COHERE Finland is dated from 2020, right?
A. Yes.
Q. Did you include that report or reference it in your disclosure?
A. No, I didn't -- I don't know if there would be any reason to. It was not original research of any sort; it was one committee's view on how to proceed in Finland.
Q. Did you include any other committee position statements in your report?

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A. I included the fact that many large American organizations, like the American Medical Association, American Psychiatric Association, American Psychological Association, support gender-affirming care. That within the US, there is widespread support for gender-affirming care for both minors and adults.
Q. But in other words, the fact that a position is made by a professional organization as compared to original research was not a reason to not include something in your report, right?
A. Well, that's true --
ATTY. GONZALEZ-PAGAN: Object to form.
A. -- but I view something a little bit different in terms of -- a policy statement for two clinics in Finland doesn't, to me, seem to have the same weight as, for example, WPATH, which includes experts from around the world, including many from Europe.
Q. (BY ATTY. BEDARD) Dr. Karasic, I'm going to show you what has now been marked as -- hold please, one second -- Defendant's Exhibit 13.
(Exhibit 13 marked for identification.)
Q. (BY ATTY. BEDARD) Can you see this document?
A. Yes.
Q. Have you seen this document before?

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A. Yes.
Q. And what is this document?
A. So this was -- this is a document regarding the treatment of gender dysphoria in minors at a hospital called Astrid Lindgren in the Stockholm area.
Q. And what is your understanding of the Astrid Lindgren Children's Hospital role in the provision of gender care?
A. Okay. So I know a little bit more about Sweden than Finland. I -- in my -- the Standards of Care 8 mental health chapter that I led, we do have -- one of the experts is from Sweden.
So -- and when I was there in -- either speaking in the clinic in 2009, or I was a keynote speaker at the Scandinavian Transgender Health Conference that included Swedish and Finish people in 2013, I did meet a psychologist from Astrid Lindgren. So -- but my understanding is that they were providing transgender care to minors, and then there was some controversy in Sweden, both regarding Bell v. Tavistock, and I think there was a TV show in Sweden.
And according to my colleague, who's head of the gender program at Karolinska Institute, there

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was also a real shortage of staff. And a decision was made -- so there were already long waits -- a decision was made that they would only continue -- they would continue providing care to people who had already started puberty blockers. So people who were already enrolled in care could continue in care.
That new patients, in order to receive care, would have to join a study. And the study was to gather more information, basically, on gender-affirming care in minors.
Q. And you've referenced a couple of times, Dr. Karasic, the Bell v. Tavistock decision. Can you tell us more about that?
A. Yeah. So my understanding of the case was that it related to the ability of minors to consent in the UK. And there was a person who I think had de-transitioned who was, I think, Keira Bell.
And there was an initial court case about the validity of consent that put an effective halt for a little while on minors getting care in the UK, and then it was reversed. And so a higher court, I presume, reversed the case. And so it no longer has any effect -- any legal effect in the UK.
Q. Were you personally involved in that case in the UK?

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A. No.
Q. And it's your understanding that the current status of that case is that there is no longer a block or ban or halt on the provision of gender-related care for minors?
A. In the UK, right.
Q. In the UK?
A. Yeah. Yes.
Q. And you have referenced that case in the context of several other European studies that we've also discussed. And so what is your understanding of how that case may have impacted -- may have impacted the provision of gender-related care for minors in other countries?
ATTY. GONZALEZ-PAGAN: Objection to form. Misrepresents the nature of the exhibits.
A. Okay. Well, I say that just because that was my understanding, having talked to the -- you know, I was already in discussion, regular discussion with my Standards of Care 8 chapter, with the head of the gender clinic at Karolinska Institute, which was the clinic for adults. She had previously introduced me to somebody from Astrid Lindgren years ago. And so in our conversations, I just -- you know, I asked what was going on in Sweden while this was

happening, so a while back.
And she had said that there was, you know, as head of her program, that there was political pressure that was related to this lawsuit in the UK. I think as well as a television program -- an episode of a television program in Sweden. And so she had said this was -- what happened at Astrid Lindgren was reactive to those things going on.
Q. (BY ATTY. BEDARD) So circling back, then, to the Astrid Lindgren decision --
A. Mm-hmm.
Q. -- is your understanding, is that decision is to no longer provide puberty blockers, testosterone or hormone treatment, and gender-care related surgery to minors outside of the clinical trial setting?
A. So my understanding is that they were continuing -- they will continue -- they would continue to provide care to anyone who had already been admitted to their program.
So anyone already part of their program would continue to get puberty blockers and hormones. And that new patients, in order to access care at Astrid Lindgren, would have to enroll in a clinical trial. Basically, they would get their care, but it would be observed, you know, data would be collected in

that clinical trial.
Q. Understood. Okay. So let's go back, then, to that exhibit, to the Astrid Lindgren guidelines. Can you see the document again, Exhibit 13?
A. Yes.
Q. And I'm going to direct you to the last full paragraph on the first page from the guidelines that begins with "these treatments." Do you see that paragraph?
A. "These treatments" -- okay.
Q. Yeah, I'll scroll up.
A. Yeah.
Q. Okay. Could you read that photograph for us?
A. "These treatments are potentially fraught with extensive and irreversible adverse consequences such as cardiovascular disease, osteoporosis, infertility, increased cancer risk, and thrombosis. This makes it challenging to assess the risk/benefit for the individual patient, and even more challenging for minors or their guardians to be in the position of an informed stance regarding these treatments."
Q. So Dr. Karasic, what is your response to this guideline?
ATTY. GONZALEZ-PAGAN: Objection to form.

A. Or if you mean that paragraph, I think that -- well, I disagree with it. And I think that even the, you know, director of the gender program at Karolinska Institute would disagree.
That because there are -- it lists things that -- where there is controversy or discussion perhaps in adults but certainly not in youth, there's no evidence of increased cardiovascular disease in youth; osteoporosis, while there's, you know, variable data in terms of bone density, osteoporosis is really a disease of much older people; infertility, you know, we've discussed, is something that can happen with, you know, people over the course of transitioning, but is not necessarily, you know, something if somebody's entering a program for puberty blockers that could still be fertile if they stopped the puberty blockers; increased cancer risk, there's no evidence of that in minors; or thrombosis.
And so each of these are potential side effects of concern that are, you know, discussed and followed in adults. And certainly in adults, one, you know, discusses risks and benefits of treatment, like any treatment. But they're not really applicable to minors, nor are they more of a concern

than -- or a concern that necessarily outweighs the benefits of treatment, such that certainly transgender care in adults. One weighs risks and benefits, and, you know, and people have been consenting, you know, to that as adults to that care.
But this conflates the various potential concerns of adverse consequences in adults with a decision in youth.
Q. (BY ATTY. BEDARD) Well, Dr. Karasic, I think what I understand you saying is that some of these side effects, such as cardiovascular disease or osteoporosis, typically present in adults rather than in minors, right?
A. Yes.
Q. Okay. So let me ask it this way, then. Let's take cardiovascular disease, for example. Are there studies of adults who received gender-related treatments, therapies, as minors on the long-term impacts of those treatments once they become adults?
A. Well, the Dutch are saying they're going to be releasing more long-term research as it happens. Long-term research of, let's say, somebody -- if somebody started on puberty blockers when they're 12 years old. And hip fractures don't tend to happen

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until people are at least in their 50s. So we would have to wait 40 years before someone's enrolled in the study and when we might have a full picture of its impact on hip fractures.

So it's difficult to -- to say, with the exception of the Dutch, because they did start some people on puberty blockers in the 1980s, you know, that we need to wait for, you know, 40 years to see.

But for example, in adults, I mentioned the Wiepjes study that, you know, that in terms of bone fractures, there doesn't seem to be an impact before age 50. And then in -- or in people -- or in trans men. And that for trans women, their risk is closer to cisgender women as opposed to cisgender men once they're in their 50s.

But we're not, from our -- you know, American longitudinal research is going to take quite a long time before we can see the people started on puberty blockers in America at age 12, whether -- what, you know, what all -- all of, you know, like, the research into what happens when they're elderly. So in the meantime, we try to explain risks and benefits of interventions to people.

There has been mixed data on cardiovascular disease in trans people. Some of it may be related

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to things other than hormones, like increased smoking. I know one study.

And so, you know, these are all areas of interest or areas of research, but the -- the fact that there could be potential long-term side effects of one particular intervention has to be weighed against the benefits, like we do for anything. You know, we know that serotonin reuptake inhibiters, long-term use of them can increase the use of hip fractures. But it's rare that people are given informed consent, even for that with SSRIs.

So, you know, this is part of the work that we do with all of our patients whenever we prescribe anything, is to try to give them a full picture of the risks and benefits.

Q. Dr. Karasic, I'm going to show you now what has been marked as Defendant's Exhibit 14. As I get this pulled up, are you aware of who Dr. Hilary Cass is?

A. Yes.

Q. And who is she?

A. My understanding is that she is leading an ongoing process of evaluating transgender care for minors in the UK.

Q. And have you reviewed any reports released from her research?

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A. Yeah. So it's -- my understanding is that she is doing a -- that she's done an interim report with recommendations for improving and even expanding care in the UK. And so it's not original research, in terms of providing outcomes of interventions, but she's trying to make an assessment of care as it is in the UK and how it might be improved.

Q. And she was appointed by the NHS to make that assessment and to provide that report, right?

A. That's my understanding.

ATTY. GONZALEZ-PAGAN: Objection. Form.

ATTY. BEDARD: Let's take a look at that report.

(Exhibit 14 marked for identification.)

Q. (BY ATTY. BEDARD) I'm showing you what's been marked as Defendant's Exhibit 14. Can you see that?

A. Yes.

Q. And is this the interim report you were referring to?

A. Yes.

Q. It's dated February of this year, of 2022, right?

A. Yes.

Q. Do you see the section starting with "Existing evidence base," on the bottom of Page 18?

A. Yes. I see just the first part of the sentence

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there, because the lower --

Q. Okay.

A. Yeah, okay.

Q. And can you read that first paragraph for me, beginning with 1.23?

A. Yes. "Evidence on the appropriate management of children and young people with gender incongruence and dysphoria is inconclusive both nationally and internationally."

Q. And what is your response to this statement and Dr. Cass's interim report?

A. Well, she says "inconclusive," and the question is inconclusive as to what?

Q. Well, you have read this interim report, right?

A. Well, I don't remember everything that was said, but it sounds like -- well, it says that she says that it's inconclusive.

So the question as to what -- when I say appropriate -- it's saying "evidence on the appropriate management," so that doesn't necessarily mean that's inconclusive whether or not to provide care or not to provide care. It's -- the question is, "What's the appropriate course? What's the appropriate strategy to provide care?" And I believe elsewhere in the study, it refers to, for

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example, the long waits to get care. So appropriate management might be easing access to care, not just restricting it.
Q. And do you reference Dr. Cass's interim report in your disclosure?
A. No.
Q. Okay. And why not?
A. It's not -- it's a government review of transgender care for minors in the UK. It's not a study of the, you know, of interventions or their response, or of surveys in their response to -- of trans people to get care. A government --
Q. But, Dr. Karasic --
A. It's an interim government report that mostly is talking about, like, how to proceed in the UK.
Q. But Dr. Karasic, you do not fully rely on what you refer to as "original studies" in your report, right?
A. Well, I also rely on 30 years of clinical experience and the experience of my peers. We have been working with transgender youth for decades, using the information that was available at the time. Each additional bit of information is interesting and helpful, but we don't rely on one particular study or report.

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ATTY. BEDARD: Dr. Karasic, I'm now going to show you what has been marked at Defendant's Exhibit 15.
(Exhibit 15 marked for identification.)
Q. (BY ATTY. BEDARD) And as I do so, have you -- let me back up.
Are you aware that this year, the State of Florida released a Medicaid report on gender dysphoria?
A. Yes.
Q. And have you reviewed that report?
A. Just very superficially. I looked at who was involved, and it seemed to me that it was really a political sham as opposed to any serious report. It was -- one of the reports was from a Canadian dentist, and another was from an expert on pedophilia, who has admitted in court that he has never cared for a transgender minor.
And so it seemed like they were selecting people from Canada who had never cared for -- never provided transgender care, to justify a political maneuver that had nothing to do with trans care. So it really didn't seem worth my while to read it in any more detail. I thought it was a ridiculous effort.

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Q. So let me show you what's been marked as Defendant's Exhibit 15. Is this the report you're referring to?
A. Yeah, I think so. I saw something on it where it listed the people who were doing individual reports. And so -- but I assume that that was it.
Q. Okay. Well, let me scroll down, because I do want to make sure we are talking about the same report. Is there a specific section of this report that would be helpful to look at?
A. No, I can't say I reviewed the whole report in detail, because just looking at it, as I said, I saw -- from what I saw, it did not seem like anyone who was involved, that I could see, were people who had something to contribute to the discussion in transgender health. But rather, it was really more of a political scheme.
Q. So Dr. Karasic, I guess I'm just -- I'm trying to understand. The criticisms that I have heard you voice today are in part -- of this specific report, are in part based on the contributors to the report, right?
A. Right. I may have skimmed over a little bit of the contents, but I can't say I've read the whole thing in detail, nor that it would -- that there would be a reason for me to do so, in terms of -- you know,

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certainly in terms of the -- even the original expert report that I provided, I believe, was before this came out. And I can't imagine that there's anything there that, because -- yeah, I did, you know, there was, like, a little update recently, but I had done the expert statement a while back, before this came out, and there wasn't anything that seemed, you know, that it would contribute to any change in my opinion.
Q. So just so we're on the same page, Dr. Karasic, are the comments that you've made about the document that's in front of us as Exhibit 15 specifically, or are you not sure whether or not you have previously reviewed this exhibit prior to today?
ATTY. GONZALEZ-PAGAN: Object to form. Asked and answered.
A. As I said, I think I reviewed it very briefly, but did not -- you know, to see if there was anything useful in there, and concluded that there wasn't. You can feel free to bring up a paragraph, if you'd like, and I'm happy to comment on that paragraph.
Q. (BY ATTY. BEDARD) Sure. And before I do so, I do want to better understand, because I think part of the -- some of the comments that you've made today have to do with the contributors to this report or

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to a similar report. So is there a section of this report you looked at that describes who contributed to the report?

A. I did -- I read something where it looked like there was a pair of contributors that were led by a Canadian dentist, and then there was one by James Cantor who -- James Cantor is an expert on pedophilia, but has not provided, as he's admitted in court, has not ever provided transgender care.

So here, when you go to Attachment C and Attachment D: Attachment C is from the dentist, the Canadian dentist; and Attachment D is from James Cantor, a Canadian pedophilia researcher and maybe advocate for understanding and acceptance? And -- which seemed a curious choice of expert, because he has never provided care for any transgender minors, as he has, you know, admitted in court.

Q. And are you familiar with the assessments cited as Attachments E, F, and G?

A. Well, Dr. Lappert, I believe, was involved, I think in making an expert statement on a previous case. And -- but also it just -- it seemed to me that these were political choices, as opposed to anyone who's ever done, you know, people who have actually taken care of a trans person or done actual research

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working with trans people. It seemed like a -- not a serious document, to me.

Q. So for the -- for the doctors referenced in Attachments E, F, and G -- so Dr. Van Meter, Dr. Lappert, and Dr. Donovan -- do you know whether they have ever treated patients who have --

A. So first of all, I did want -- I did want to say --

Q. Sorry, Dr. Karasic, if you can just wait one second until I finish my question before you answer, that would be great.

A. Sorry.

Q. I know it's tough, with the remote depo in particular. Just -- I'll restate my question.

For Dr. Van Meter, Dr. Lappert, and Dr. Donovan, do you know whether they treat patients who identify as transgender?

A. So I'm sorry I interrupted, I had wanted to finish my comment about the previous authors, which I do believe I read enough of it that James Cantor did support transgender care for adults -- that he was raising questions about transgender care for youth.

Lappert, I think, was an expert in a case I was involved in. You'll have to move everything up a little bit for me to see more.

Q. Sure.

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A. I don't know who G. Kevin Donovan is. Never heard of Quentin Van Meter.

Q. Understood. So I'm scrolling down now to Page 3 of this report, Dr. Karasic.

A. Yes.

Q. And there is a paragraph starting with, "Following a review." Could you read that paragraph for us?

A. "Following a review of available literature, clinical guidelines, and coverage by other insurers and nations, Florida Medicaid has determined that the research supporting sex reassignment surgery is insufficient to demonstrate efficacy and safety. In addition, numerous studies, including the reports provided by the clinical and technical experts listed above, identify poor methods and the certainty of irreversible physical changes. Considering the weak evidence supporting the use of puberty suppression, cross-sex hormones, and surgical procedures when compared to stronger research demonstrating the permanent effects they cause, these treatments do not conform to GAPMS and are experimental and investigational."

Q. And Dr. Karasic, what is your response to that statement?

A. I think this entire report is just ridiculous. It's

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not a serious effort, from even skimming over it. There's nothing serious about it. It is -- it was an attempt by Governor DeSantis to shut down transgender care in a purely political move in the same way that Florida has been playing politics on LGBT issues more broadly.

And it's a shame that low-income people, the people on Medicaid in Florida, have to suffer because of this political grandstanding. And that they couldn't find any real experts, and so they found these fake experts to back this up.

Q. If we could take --

A. I mean, I think it's kind of even -- I think it's even kind of shameful for you to, like, present this to me as a serious document, because it so obviously is not. So I mean, obviously you can present whatever you want, but this -- you know, the Cass report or Finland -- you know, people have their own point of views. But what's going on in Florida is not -- nothing in that paragraph has any meaning beyond the politics of what's going on in Florida right now.

ATTY. BEDARD: Dr. Karasic, why don't we take a five-minute break? Let's reconvene at 5:00 p.m. Eastern, 2:00 p.m. Pacific.

THE WITNESS: Okay.
ATTY. BEDARD: Does that work for everyone else?
THE VIDEOGRAPHER: Okay. We're going off the record at 1:53.
(Break from 1:53 p.m. to 2:01 p.m.)
THE VIDEOGRAPHER: We are back on the record at 2:01.
Q. (BY ATTY. BEDARD) Dr. Karasic, did you look at any documents during our most recent break?
A. No.
Q. And did you speak with anyone via phone, email, text during our most recent break?
A. No.
Q. And is there anything you'd like to clarify in your deposition testimony today?
A. Not that I can think of.
Q. I have no further questions, Dr. Karasic. I appreciate your time today, and enjoyed speaking with you.
A. Great. Thank you.
ATTY. GONZALEZ-PAGAN: Thank you, Stephanie. Dr. Karasic, I'm going to have a couple of follow-up questions on redirect just now, if you will.

EXAMINATION
BY ATTY. GONZALEZ-PAGAN:
Q. You were shown an exhibit, I believe it is Exhibit 14, from the defendants, a Cass -- a preliminary report by Dr. Hilary Cass in the UK. Do you recall that?
A. Yes.
Q. Okay. I'm going to try to share my screen here. Can you see the screen, Dr. Karasic?
A. Yes.
Q. I'll try to zoom a bit here. And Dr. Karasic, if you can read the second paragraph that begins with "I have heard."
A. "I have heard that young service users are particularly worried that I will suggest that services should be reduced or stopped. I want to assure you that this is absolutely not the case -- the reverse the true. I think that more services are needed for you, closer to where you live. The GIDS staff are working incredibly hard and doing their very best to see you as quickly as possible, but providing supportive care is not something that can be rushed -- each young person needs enough time and space for their personal needs to be met. So with the best will in the world, one service is not

going to be able to respond to the growing demand in a timely way."
Q. Dr. Karasic, from that statement, does it seem that Dr. Cass is recommending that care be reduced or stopped for gender-dysphoric youth in the United Kingdom?
A. No.
Q. I'm going to just move to another page, if you will. This is Page 15 of the PDF. Dr. Karasic, do you see the paragraph that's numbered 1.5?
A. Yes.
Q. Do you mind reading that into the record?
A. "The review is not able to provide definitive advice on the use of puberty blockers and feminizing/masculinising [sic] hormones at this stage, due to gaps in the evidence base; however, recommendations will be developed as our research programme progresses."
Q. Dr. Karasic, is it your understanding that the Cass review from February of 2022 is making any recommendations as to the provision of gender-affirming care, such as puberty blockers and hormones at this time?
A. My understanding is they are not.
Q. Okay. And is it your understanding that the review

is actually ongoing?
A. Yes.
Q. Dr. Karasic, you were previously shown what's been marked as Defendant's Exhibit 13, where -- pertaining to a statement by the Astrid Lindgren Children's Hospital. Do you recall that?
A. Yes.
Q. To your knowledge, is that statement peer-reviewed?
A. No.
Q. And that statement pertains to solely one hospital; is that correct?
A. That statement is specific to Astrid Lindgren Hospital.
Q. Okay. And do you recall discussing side effects from hormone treatments such as cardiovascular disease, osteoporosis, infertility, increased cancer risk, and thrombosis?
A. That was brought up in this deposition, yes.
Q. Okay. Dr. Karasic, are the side effects of the provision of hormones unique when -- because they're being provided for the treatment of gender dysphoria?
A. No. So hormones that are provided for other purposes also can cause side effects. As a matter of fact, almost everything we prescribe has a

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potential for side effects.
THE WITNESS: I lost you for a moment.
ATTY. GONZALEZ-PAGAN: Apologies.
Q. (BY ATTY. GONZALEZ-PAGAN) Every medical treatment has risks and benefits; is that right?
A. Yes.
Q. Dr. Karasic, to your knowledge, is the -- well, let me go back.
Dr. Karasic, do you recall reviewing a summary of a recommendation by COHERE? Do you recall that?
A. Yes.
Q. Okay. That is a summary of a report; is that correct?
A. Yes.
Q. Okay. But it's not the full report; is that right?
A. Yes.
Q. That is also -- is the summary of the recommendation by COHERE peer-reviewed?
A. No.
Q. Okay. And COHERE is a governmental entity in Finland; is that correct?
A. That's my understanding, is it's a governmental committee of some sort.
Q. All right. Dr. Karasic, do you recall going through Exhibit 10 -- where is Exhibit 10? -- an informed

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consent form, a consent form regarding surgery?
A. Yes.
ATTY. GONZALEZ-PAGAN: Stephanie, I apologize. If you can recall for me which exhibit it is, that ASA informed consent form, it might make it move faster. But if not, I can find it.
ATTY. BEDARD: No, that's fine. I can pull it up for you, if you'd like.
ATTY. GONZALEZ-PAGAN: That'd be great. Thank you. I really appreciate it.
ATTY. BEDARD: It's the most recent Polyclinic records.
ATTY. GONZALEZ-PAGAN: Correct, yeah. I'm not sure if it's 5 or 10.
ATTY. BEDARD: No, it's 10. Do you want me to share my screen?
ATTY. GONZALEZ-PAGAN: If you don't mind, that would be appreciated.
ATTY. BEDARD: Sure. No, it's not 10. It's 3.
ATTY. GONZALEZ-PAGAN: Yeah, it's 3. Yeah, okay, that's what I was --
ATTY. BEDARD: It's 3, and I'm happy to share my screen. I will be the one with control -- I don't think I can share control, so you'll just have to let me know where you want to go.

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ATTY. GONZALEZ-PAGAN: It's all right. I can -- if you wouldn't mind, stop sharing. I have it in front of me. I apologize.
ATTY. BEDARD: Okay.
Q. (BY ATTY. GONZALEZ-PAGAN) Dr. Karasic, do you remember being shown a Consent for Surgery form from the Polyclinic earlier today?
A. Yes.
Q. I'm going to share my screen with you. Can you see that?
A. Yes.
Q. Okay. Dr. Karasic, and I know that it's a bit fuzzy, but if you could read Paragraph 11?
A. "The above treatment or procedure has been explained to me in a way that I understand. I realize that there may be alternative procedures or methods of treatment, and that there are risks to the procedure or treatment proposed."
Q. Thank you. From your understanding, is it -- actually, and if you don't mind reading the next sentence thereafter, beginning "in signing"?
A. "In signing this consent, you acknowledge that you have been informed about the risks and benefits for this surgery/procedure, and accept responsibility for the clinical decisions that were made along with

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the financial costs of all future treatments."
Q. Based on your review of this document and those sentences, is it your understanding that risk and consequences of the surgery -- in this case, a bilateral mastectomy -- were discussed with C. P. and his parents?
A. Yes. It seems like there's an acknowledgment of it. The form is a fairly generic form, but it includes -- they're acknowledging that there has been a discussion. So I wouldn't view the form as a discussion, but rather the acknowledgment that a discussion has taken place.
Q. Thank you. And earlier, you were asked some questions about the fact that C. P.'s father signed under the "Witness Signature" line. Do you recall that?
A. Yes.
Q. Isn't it true that there's a third signature just below the witness signature for a Sue Harrington, RN?
A. Yes. Can you scroll up? Just because it's being blocked by my --
Q. Can you see that now?
A. Yeah. So it looks like there's a witness signature below, on the third line. And so, again, it was a

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stock form, I assume, for adults. So it didn't have a parent signature like forms typically do when they're for procedures on minors.

Q. Is it your understanding, then, that there's at least a parent who could provide consent, a minor who could provide assent, and a distinct witness, all of whom have signed this form?

A. Yes.

Q. All right. Dr. Karasic, earlier you were asked some questions about the effects of puberty blockers on bone density. Do you recall that?

A. Yes.

Q. Are the effects of puberty blockers on bone density primarily a concern when the production of sex hormones is being blocked and no other sex hormones are being provided?

A. It's primarily a concern --

ATY. BEDARD: Object to form.

A. It's primarily a concern when there is long-term use. For example, some adults who might be without either testosterone or estrogen, there can be a long-term concern for osteoporosis. And so the data for short-term use in youth were not generally -- even if there's some change in bone density where the data's mixed, we're not -- it's not really a

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concern in terms of the function of the bone, then, because from the data we have, fractures don't become an issue for people until -- fractures due to osteoporosis become an issue for people much later in life.

Q. (BY ATTY. GONZALEZ-PAGAN) Does the provision of sex hormones, whether because the puberty blockers have been stopped or they've been provided in an exogenous manner, dissipate the concern about bone density?

ATY. BEDARD: Object to form.

A. Yeah. So as I said, there's variable data in terms of what happened in bone density in people provided puberty blockers. And -- but bone density tends to increase again with the start of gender-affirming hormones, such that people have bone growth that appears equivalent to that of the gender to which they've transitioned.

ATY. GONZALEZ-PAGAN: Thank you, Dr. Karasic. No more questions, and I'll stop sharing the screen.

ATY. BEDARD: I have no further questions either.

THE VIDEOGRAPHER: Okay. That concludes the deposition. The time is 2:16 p.m. We are going off the record.

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ATY. GONZALEZ-PAGAN: We will read.

THE COURT REPORTER: And orders, Counsel?

ATY. BEDARD: Let's say non-expedited for now, and if need be, I'll circle up with our team and let you know as soon as possible if that changes.

ATY. GONZALEZ-PAGAN: The same for us.

(Deposition concluded at 2:17 p.m.)

(Signature reserved.)

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July 25, 2022

To: Omar Gonzalez-Pagan
Lambda Legal Defense and Education Fund, Inc.
120 Wall Street, 19th Floor
New York, NY 10005-3919

Re: Pritchard, et al, v. BCBS of Illinois
Deposition of: Dan H. Karasic, MD
Date Taken: July 13, 2022
Cause No.: 3:20-cv-06145-RJB

Enclosed are the Correction & Signature page. Instruct the deponent to review the deposition, record any corrections on the Correction page, and sign it.

The above referenced transcript must be read and the Correction & Signature page signed within 30 days of this notice or before the trial date, whichever occurs first.

If the Correction & Signature page are not signed within that time period, signature will be deemed waived for all purposes.

After the Correction & Signature page are signed, please forward to:

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Thank you,
Sierra Zanghi, RSR, CCR
CCR No. 22004202

CORRECTION AND SIGNATURE PAGE

Re: Pritchard, et al, v. BCBS of Illinois
Deposition of: Dan H. Karasic, MD
Date Taken: July 13, 2022
Cause No.: 3:20-cv-06145-RJB

I, DAN H. KARASIC, MD, have read the within transcript taken July 13, 2022, and the same is true and accurate, except for any changes and/or corrections, if any, as follows:

PAGE/LINE	CORRECTION	REASON

Signed at _____ _____
City State

_____ _____
Dan H. Karasic, MD Date

See: Wash. Reports 34A, Rule 30(e), USCA 28, Rule 30(e)

C E R T I F I C A T E

STATE OF WASHINGTON)
) ss.
COUNTY OF SNOHOMISH)

I, Sierra Zanghi, Certified Court Reporter in and for the State of Washington, reported the within and foregoing deposition of Dan H. Karasic, MD on Wednesday, July 13, 2022; that pursuant to RCW 5.28.010 the witness was first by me duly sworn; that said examination was taken by me in shorthand and thereafter under my supervision transcribed; that in accordance with CR 30(e), the witness was given the opportunity to examine, read, and sign the deposition within 30 days, upon its completion and submission, unless waiver of signature was indicated in the record; and that same is a full, true and correct record of the testimony of said witness, including all questions, answers, and objections, if any, of counsel.

I further certify that I am not a relative or employee or attorney or counsel of any of the parties, nor am I financially interested in the outcome of the cause.

This transcript and billing has been prepared/submitted for final preparation and delivery in accordance with all Washington State laws, court rules, and regulations.

Rules regulating formatting and equal terms requirements have been adhered to. Alterations, changes, fees, or charges that violate any of these provision are not authorized by me and are not at my direction or with my knowledge.

IN WITNESS WHEREOF I have set my hand this 25th day of July, 2022.

Sierra Zanghi

SIERRA ZANGHI, RSR,
WA CCR NO. 22004202